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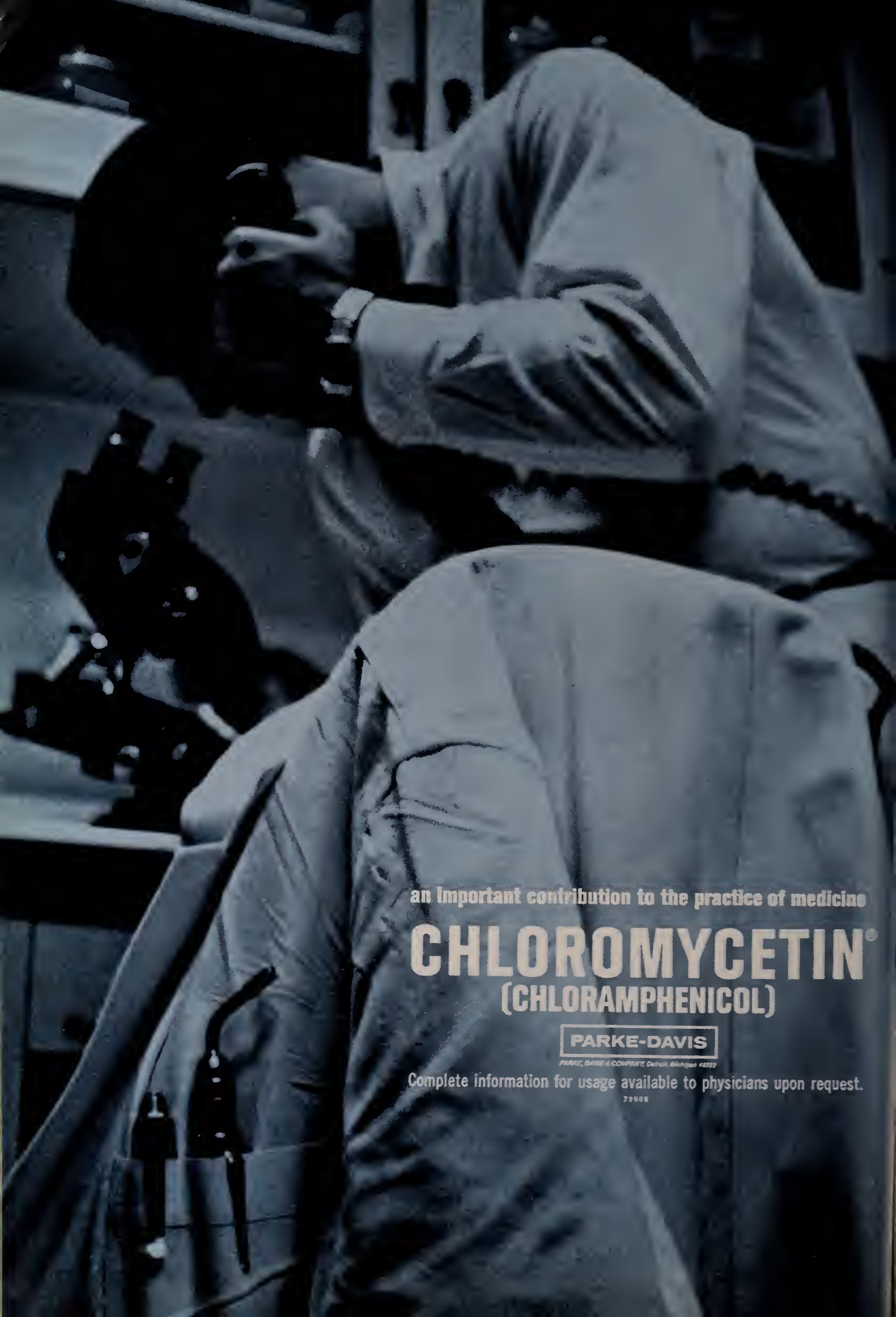
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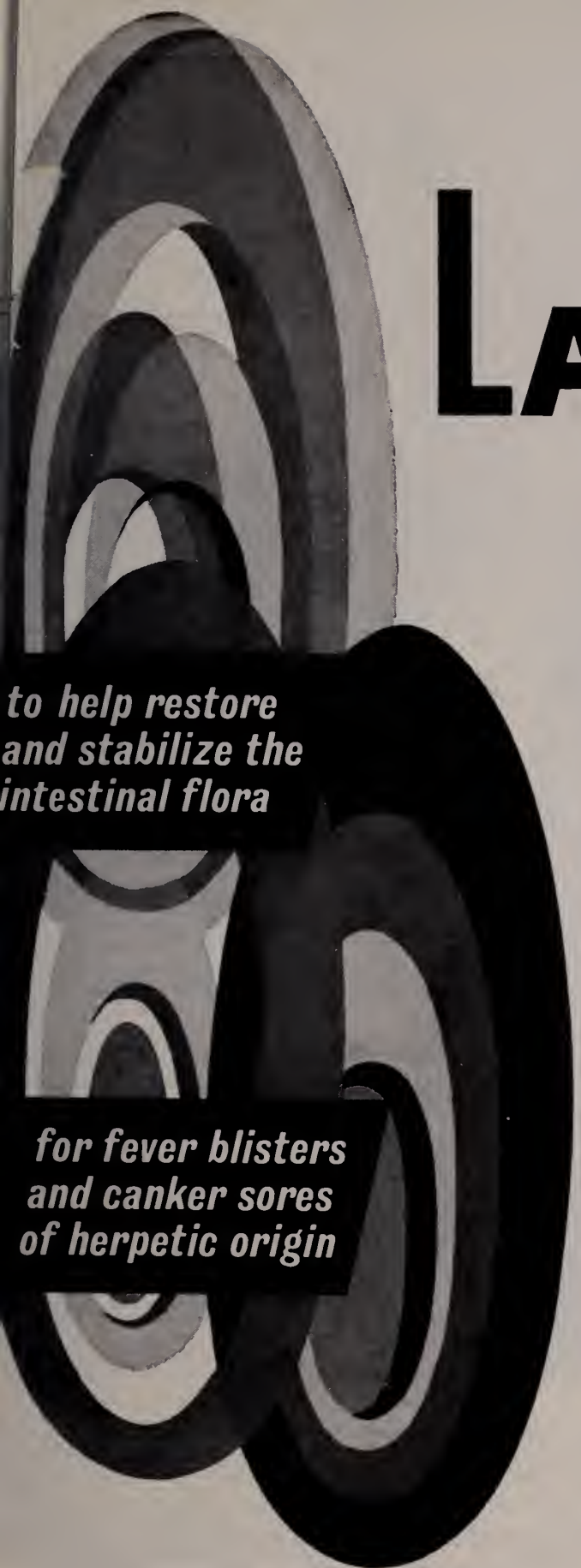
The JOURNAL of the Florida Medical Association

Is Mammography of Value?
Subareolar Breast Abscess
Hallucinations in Children
Urethrovesical Vaginal Suspension
Electromyography in Muscle Spasm
Symposium on Trauma

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(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.

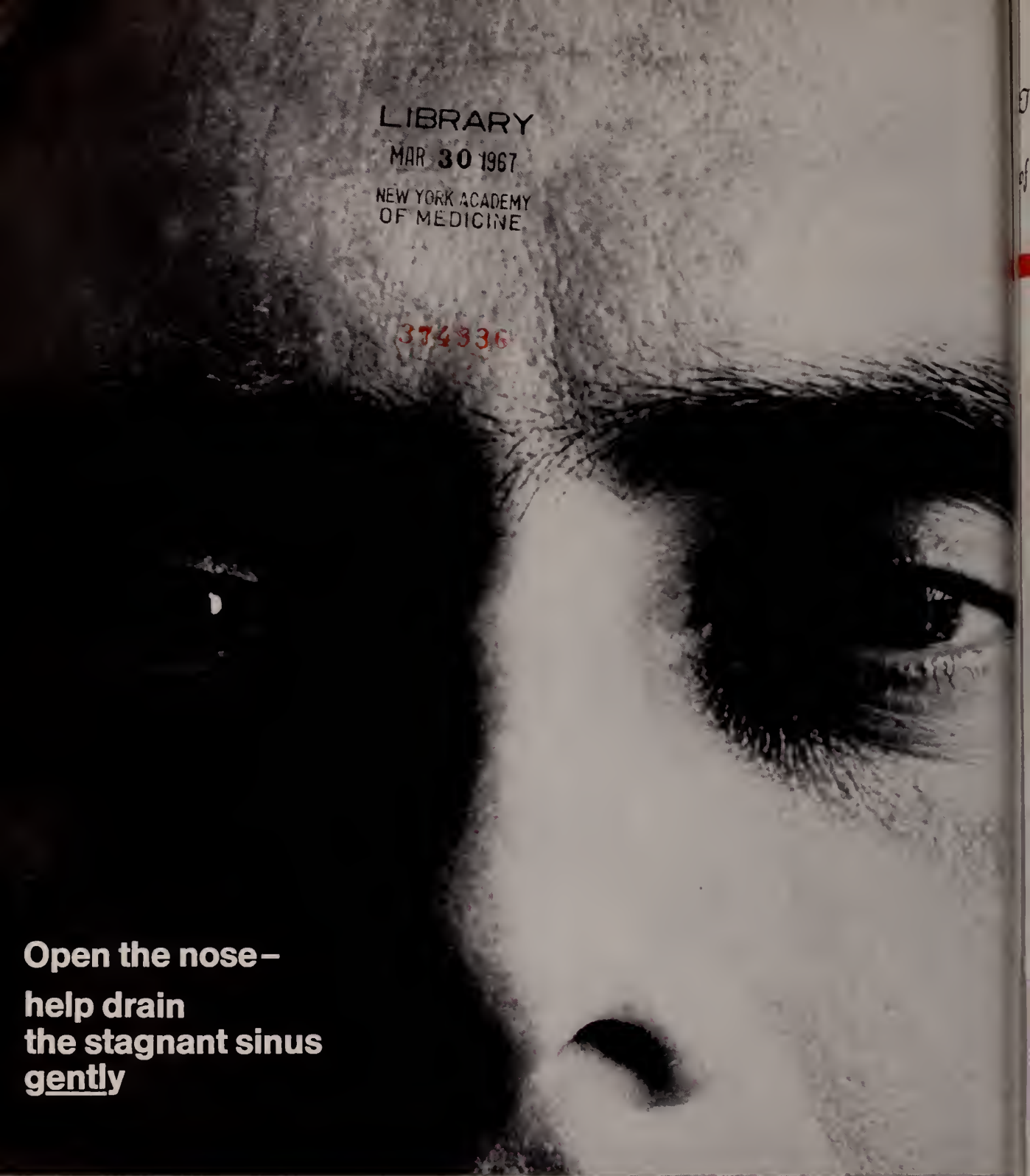
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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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of the Florida Medical Association

Volume 53, Number 1, January 1966

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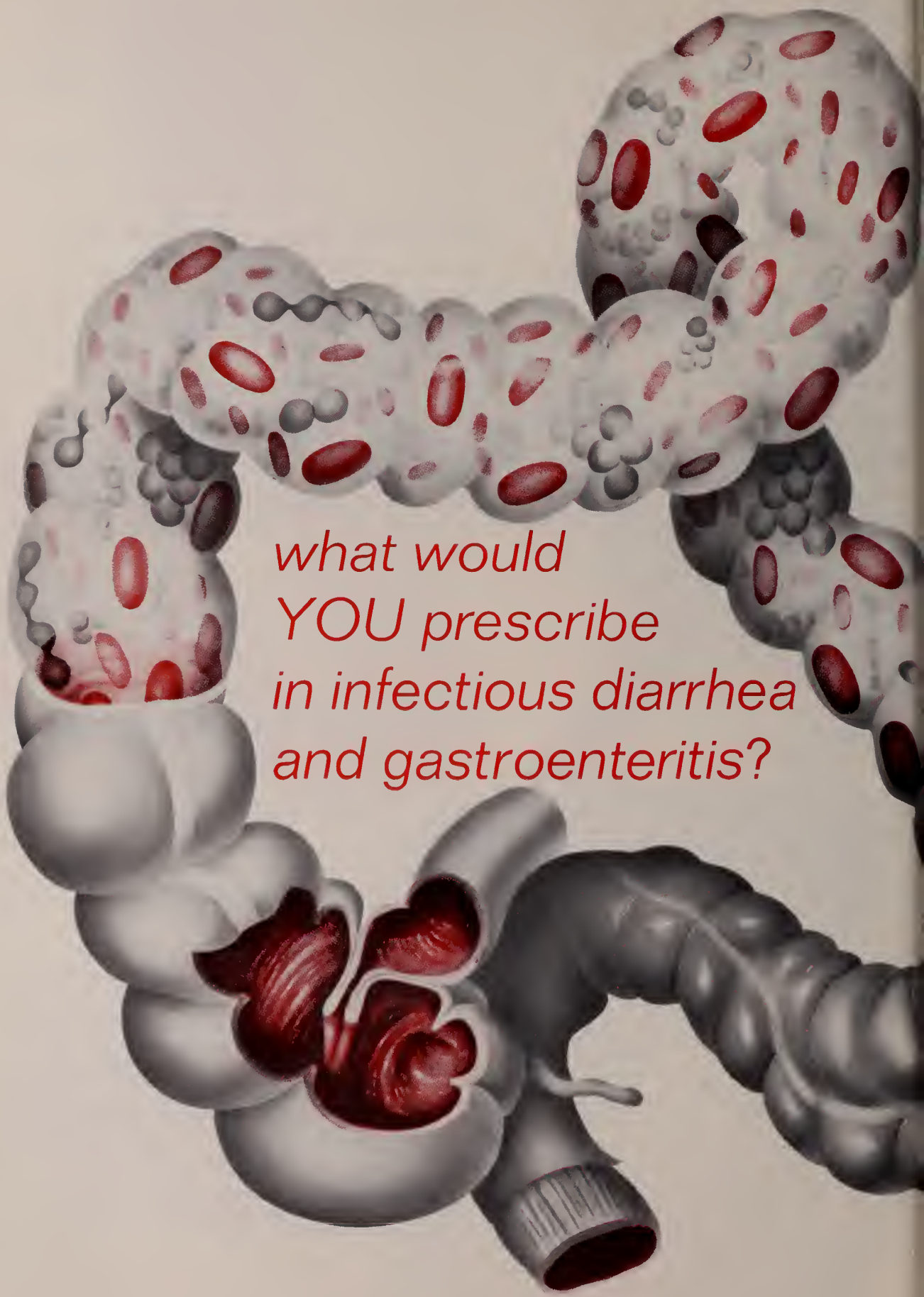
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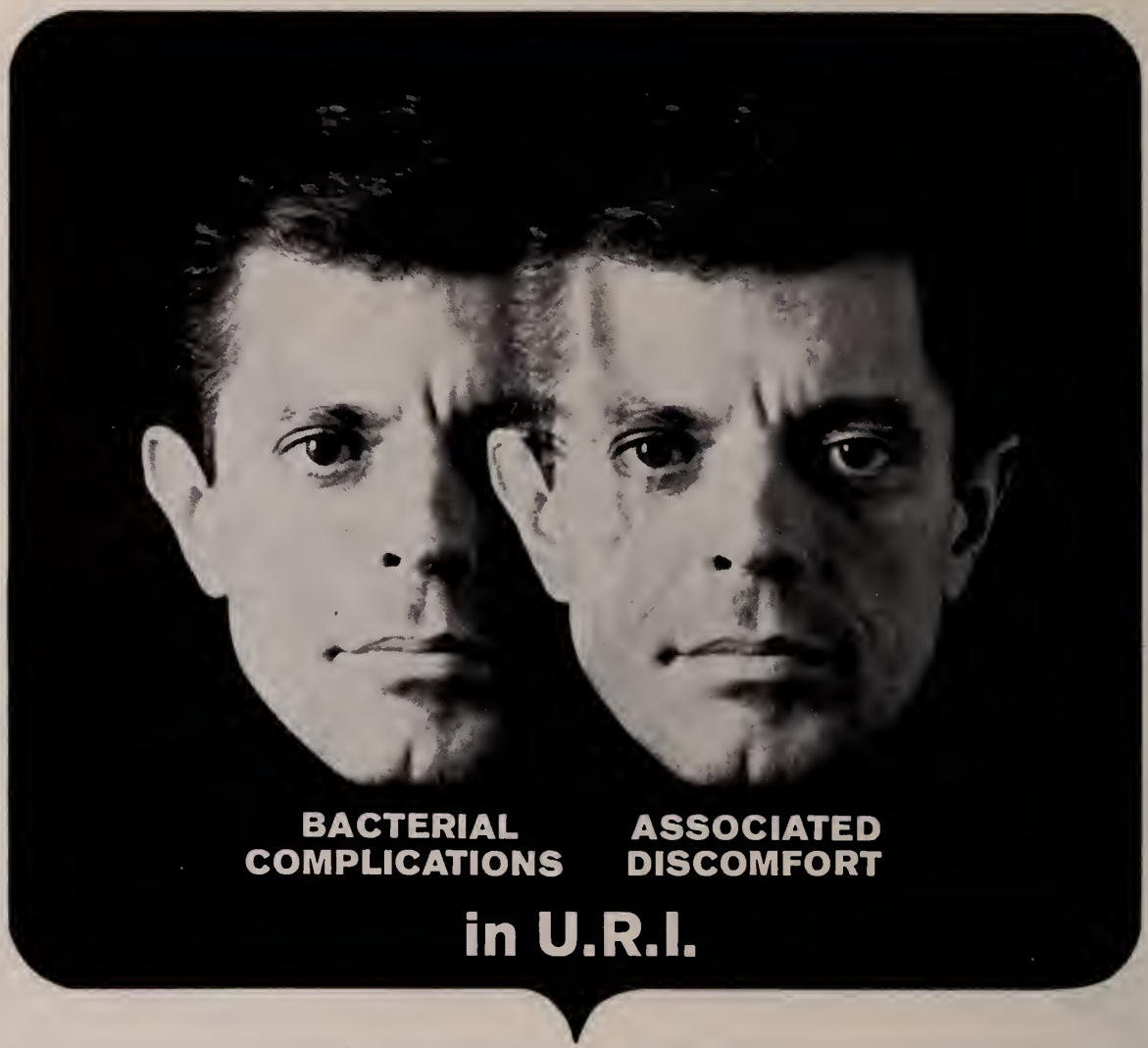
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Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

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ganisms, tooth discoloration (if given during tooth formation) and increas
intracranial pressure (in young infants). Also, very rarely, anaphylactc
reaction. Reduce dosage in impaired renal function. Because of reactions
artificial or natural sunlight (even from short exposure and at low dosag
patient should be warned to avoid direct exposure. Stop drug immediately
the first sign of adverse reaction. It should not be taken with high calciu
drugs or food; and should not be taken less than one hour before, or t
hours after meals.

Average Adult Daily Dosage: four divided doses of 1 capsule each or t
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cautions
ain a detailed history and a complete sical and laboratory examination, includ- ing a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

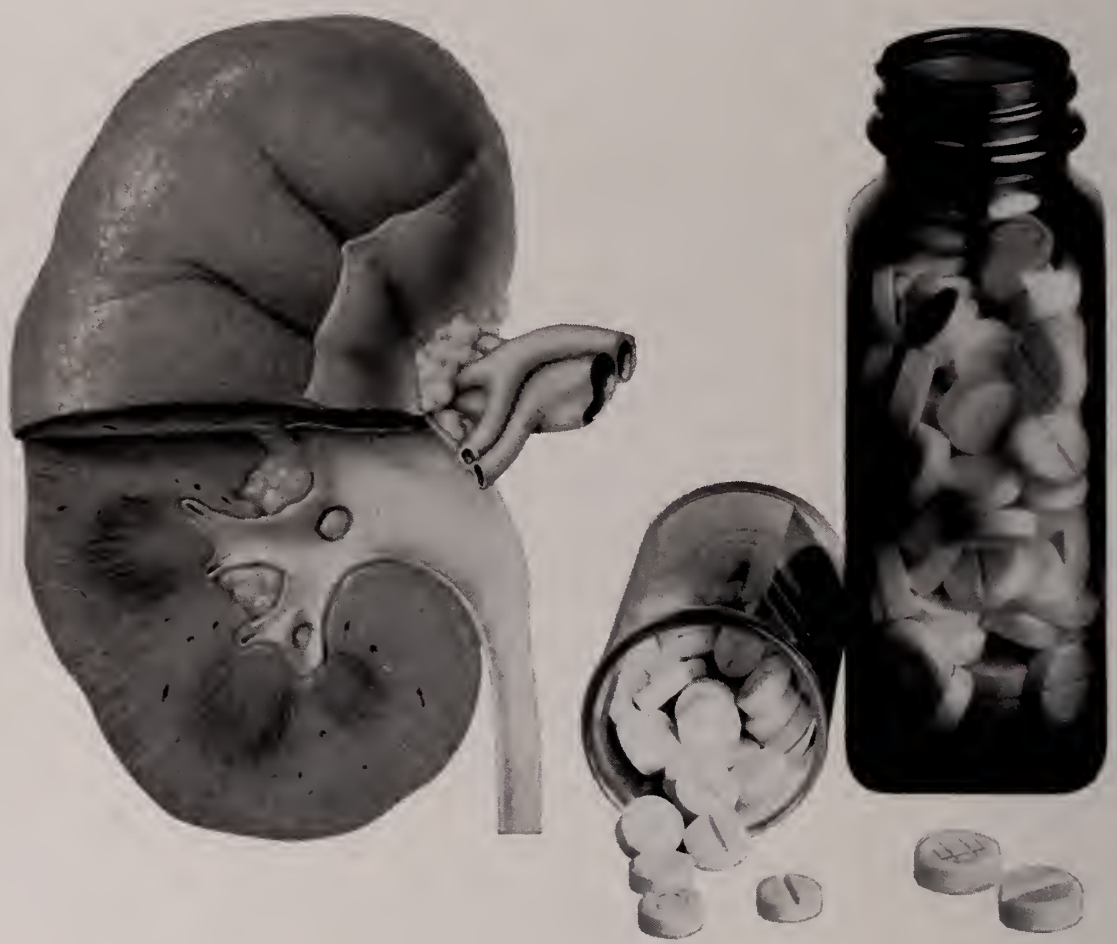
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The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

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2,448	1962	89.5%
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Indications: The bacterial spectrum includes: streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **Contraindications and Precautions:** TAO (triacetyloleandomycin) is not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents, of course, should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. It is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. **References:** 1. Isenberg, Henry D.: Health Laboratory Science 2:163-173 (July) 1965. 2. Fowler, J. Ralph et al: Clinical Medicine 70:547 (Mar.) 1963. 3. Isenberg, Henry D.: Health Laboratory Science 1:185-256 (July-Aug.) 1964.



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Dosage: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

Available in Pulvules®, suspension, drops, and chewable tablets. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

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The JOURNAL
of the Florida Medical Association

Is Mammography Of Value?

Raymond E. Parks, M.D.
MIAMI

Mammography (or mastography) is a radiographic study consisting of plain, soft tissue films of the breast without the injection of contrast material. This technique has become a widely used diagnostic procedure in the United States during the past five years. It is not a new procedure, and its use has been suggested periodically during the past three or four decades. Most attempts at adopting this technique for the diagnosis of breast masses have proved unsuccessful in the past. At the Jackson Memorial Hospital, Miami, a pilot project of 50 mammograms was made about 1955 and then the procedure was abandoned as nondiagnostic and misleading. In retrospect, it is recognized that the disappointment with the procedure at that time was due to faulty technique and inexperience in the interpretation of the mammogram. In 1960, Egan[1] reported his experience with mammography and defined the technical requirements more precisely. Since then, many confirmatory studies have been reported, establishing the value of mammography.

In 1963 a pilot study was carried out in Florida, sponsored by the Florida Division of the American Cancer Society, to evaluate the diagnostic accuracy of mammography. Patients scheduled for breast biopsy were submitted for mammography studies preoperatively at hospitals in Miami, Tampa, Jacksonville, and Gainesville. Comparison of the radiographic diagnosis and pathological diagnosis was made in over 1,500 cases. There was correct correlation in 85% of the cases with regard to the presence of benign or malignant disease in the breast. The 15% error was approximately equally divided between false positives (diagnosed cancer on the basis of the mammogram but proved benign histologically) and false negatives (called benign or normal but proved to be malignant). As good as this record appears, it really does not tell the complete worth of this diagnostic procedure. In all of the cases examined a palpable mass was being biopsied. The greatest value of mammography probably occurs in the breast where no mass is palpable.

Mammography is a useful tool if the films are properly made and interpreted by an experienced and interested radiologist. Any radiologist can make mammograms, as they require no special equipment. The equipment usually found in any radiologist's office or hospital x-ray department can easily and inexpensively be adjusted to make mammograms. The interpretation of mammograms is not difficult and several excellent teaching aides are available.[1,2] The Cancer Institute of the National Institutes of Health has placed "mammography kits" in several parts of the country. These kits consist of tape recordings, slides, and 200 reproduced radiographs of the breast, including films at the end of the kits to test the efficiency of the learning process. These kits are available at two locations in Florida.*

Conclusions

Experiences with mammography seem to justify certain conclusions regarding the clinical worth of mammography.

1. Mammography is of greatest value in the postmenopausal patient.

The mammogram of the premenopausal breast is usually difficult to evaluate because of the large amount of persistent parenchymal ductal tissue which has the same radiographic density as neoplastic tissue. In the postmenopausal breast, this

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ductal parenchymal tissue undergoes atrophy and shows considerable fatty replacement. The fat is more radiolucent than neoplasm, and therefore, in the postmenopausal breast, one is more likely to recognize a neoplastic process. The pregnant and lactating breast is especially difficult to evaluate for cancer. It is true that cysts, discrete fibroadenomata, ductal dysplasias, scars, and other benign disease may be diagnosed in the premenopausal breast or in the lactating breast with a fairly high index of accuracy. Cancer, however, cannot be excluded in any of these cases, and if it coexists, it will probably be missed. The use of mammography for the exclusive detection or definition of benign disease is usually unimportant, since such benign disease requires no treatment in most cases and the definition of benign disease by mammography does not exclude the possibility of coexisting cancer.

2. The larger the breast the more valuable the mammogram.

Large breasts are difficult to examine reliably by palpation. The largeness of the breast is usually due to an increased amount of fat which improves the diagnostic quality of the mammogram. Huge postmenopausal breasts are the ideal breasts for mammographic evaluation. The increased fat with atrophic parenchyma makes the breasts very radiolucent to the roentgen beam, and causes the more dense malignant neoplasm to be easily seen. Small female breasts or male breasts are better evaluated by physical examination than by mammography.

3. Mammography will not prevent or delay a proposed breast biopsy.

When, on the basis of history or physical findings, a breast biopsy is indicated, nothing that mammography can demonstrate will defer the need for this biopsy. If the radiographic study shows the most typical benign radiographic changes, it still will not exclude cancer, especially microscopic malignant disease. Why then, should a patient having a breast biopsy be subjected to mammography? The mammograph is definitely indicated in every case scheduled for breast biopsy as it may show the area to be biopsied as definitely malignant, or it may show a definite malignant lesion in another quadrant of the same breast, or it may demonstrate a malignant condition in the opposite breast (fig. 1).

It would be unfortunate to subject a patient to anesthesia and breast biopsy for a benign condition, and to be unaware of a malignant condition in another part of the same breast or the opposite breast. If it can be demonstrated that the mass to be biopsied is definitely cancer, then the surgeon may substitute mastectomy for the biopsy on the philosophy that biopsy in known cancer is undesirable for fear that biopsy may disseminate cancer cells. Also, not all hospitals have facilities for frozen section of breast biopsies, and it would be most helpful to the operating surgeon to know that he is dealing with definite cancer prior to the biopsy to prevent reoperation for definitive surgery.



Fig. 1. — Example of unsuspected carcinoma in the opposite breast. A 46 year old woman with a palpable mass in the right breast was admitted for biopsy, which proved to be benign fibrocystic disease. The mammograph of the opposite breast shows a typical primary scirrhous carcinoma nodule deep in the left breast (arrows pointing to carcinoma).

It must be emphasized again that nothing the mammogram will demonstrate will permit a cancellation of a proposed biopsy. If the clinician is sufficiently suspicious of a breast nodule to justify biopsy, then the breast biopsy should be made regardless of the mammographic findings, but the mammogram is definitely indicated to exclude a

malignant condition in another part of the same breast or in the opposite breast.

4. Mammography is a valuable routine survey tool in selected patient groups.

Mammography can be used as a routine survey study in selected asymptomatic patient groups. It is a worth while study in a postmenopausal woman with large breasts. It also is of value in the remaining breast of any patient who has had a mastectomy for cancer. We have also found mammography valuable in detecting a primary malignant state when the patient is known to have metastatic malignant disease of unknown origin. Proof of a primary site in the breast is of clinical value because metastatic breast cancer involves different management than metastatic cancer from other organs (fig. 2).

Mammography is well accepted by the patient and proves a valuable tool to the clinician if he understands its applications and limitations. It is painless, requires no preparation on the patient's part and can be done on an in-patient or out-patient basis. The cost of mammography is about the same as the cost of a routine cervical spine x-ray.



Fig. 2. — Example of clinical occult primary breast carcinoma in a 55 year old woman admitted because of an axillary node enlargement. Excision of the lymph node showed on microscopic examination: "Mucus forming carcinoma (signet cell type), probably of G. I. tract origin." Physical examination of both breasts by two experienced surgeons and x-ray studies of the gastrointestinal tract gave negative results. Mammograph shows typical findings of a primary malignant tumor. Histological study of the mastectomy specimen confirmed the mammography findings.

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Chronic Subareolar Breast Abscess

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Recurrent subareolar abscess is an infrequent but troublesome disease of the breast. It may be confused with lactation abscess, but actually is an entirely different clinical entity, with a different pathogenesis, and requires different therapy.

Chronic subareolar abscess usually develops in younger women, but not in those who have recently gone through pregnancy and lactation. It begins as a small rather low grade area of inflammation in the subareolar area, usually at the edge of the areola. This evolves to form a small abscess. When it is incised and drained, the process seemingly subsides, only to flare up again in the same region after a few months. A sinus that intermittently drains pus often develops. This cycle is repeated over and over again during several years in many cases. In a series of six cases reported by Caswell and Burnett,[1] the duration of the disease was from two to 20 years. Unsuccessful treatment by repeated incisions and drainages or by local excisions of the infected area may lead to unnecessarily radical surgery. Kilgore and Fleming,[2] in their review of breast abscess, listed nine cases treated eventually by simple mastectomy. Chronic subareolar abscess is therefore a disease which is trying for both the patient and her surgeon, and which may lead to unnecessary mutilation.



Fig. 1. — Typical acute subareolar abscess. (Courtesy of Victor D. Dembrow, M.D.)

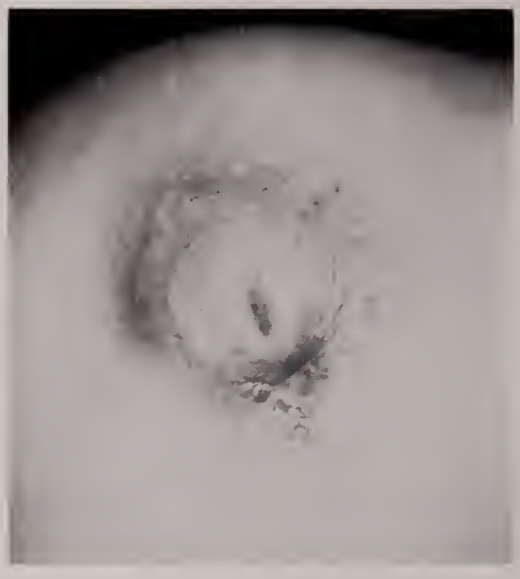


Fig. 2. — Chronic subareolar abscess with draining sinus. Note centrally invaginated nipple.



Fig. 3. — Demonstration of cutaneous nipple duct fistula.

Central invagination of the nipple is a constant finding (figs. 1 and 2). It may be possible to pass a probe through the center of the nipple, the abscess cavity, and finally the areolar sinus, demonstrating communication between these structures (fig. 3).

The following cases are representative.

Report of Cases

Case 1.—At age 24 a married mother of one developed a persistent tender mass under the right areola several years after her pregnancy. She did not nurse. The lesion waxed and waned, responding temporarily to antibiotic therapy. After several months the inflamed tissue under the areola was excised and a prophylactic excision of tissue from under the left areola was also performed. About 18 months later a spontaneously draining abscess appeared under the left areola. This was incised and drained, and developed into a periareolar sinus which failed to heal despite four weeks of dressing care and antibiotics.

On examination, the left nipple was noted to be centrally invaginated and a pasty yellowish material was caked within the cleft. Purulent matter drained from a sinus in the medial areolar margin. The right nipple was also invaginated and caked with dried pasty matter.

Case 2.—A 25 year old woman had an abscess under the right areola which drained spontaneously, but inflammation persisted for two to three months. The reaction finally subsided leaving a painful, hard area. It flared up again about six months later and again responded to antibiotics and hot soaks. One month later an abscess developed in the left breast. This was surgically drained, but failed to heal.

Examination disclosed a draining sinus in the areolar margin on the right, and an inadequately drained subareolar abscess on the left. Both nipples were invaginated.

Pathologic Considerations

Normally, the breast is composed of myriads of acini, arranged into lobules, which drain into collecting ducts that terminate in the nipple.[3] These excretory ducts are lined by columnar epithelium, but the terminal portion of each duct, within the nipple, dilates into an ampulla lined by stratified squamous epithelium. This terminal ampulla is called the milk sinus.

In recurrent subareolar breast abscess, pathological examination reveals a hugely dilated duct lying within or just beneath the nipple, lined by stratified squamous epithelium, and plugged with keratinous debris (fig. 4). At some point there is disruption of the wall of this duct, which communicates with the subareolar abscess, and with the areolar sinus if a sinus is present.

The squamous epithelium, normally found only in the widened terminal portion of the ducts within the nipple (the milk sinuses), in this disease lines the affected duct for a considerable distance as it extends into the subareolar region. It is this abnormal squamous metaplasia of the lining of the duct leading to the area of the abscess which is probably the key to the natural history

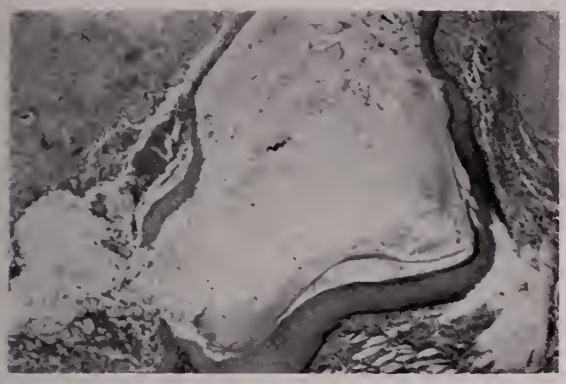


Fig. 4. — Microscopic appearance of subareolar abscess showing markedly dilated duct lined by squamous epithelium with disruption of wall.

of recurrent subareolar abscess (fig. 5). Incision and drainage, or local excision of the abscess and the fibrosis surrounding it, do not remove the source of the infection, namely, the duct lined with the abnormal squamous epithelium.

Various suggestions as to the pathogenesis of this disease have been made. Zuska, Crile and Ayres[1] stated that the disease is a variant of comedomastitis. So-called comedomastitis, however, which has been carefully described and given the more appropriate name of duct ectasia by Haagensen,[3] is an involutional phenomenon that develops in the aging breast and is a disease in which infection plays no part. Duct ectasia has no morphologic characteristics in common with chronic subareolar abscess.

Another suggestion has been that the condition develops from the sebaceous glands of the areola, like an infected sebaceous cyst. This explanation is ruled out by the fact that these abscesses are clearly related to mammary ducts situated within the substance of the nipple or in the subareolar tissue, and not to sebaceous glands in the areolar dermis.

One may speculate that the ductal epithelium undergoes squamous metaplasia as a result of hormonal influences, like genital epithelium. The answer to this suggestion is that the women in whom subareolar abscess develops appear to be entirely normal young women.

Another possibility is that the underlying cause is central invagination of the nipple, a congenital variant of gross nipple anatomy. This leads to caking within the cleft nipple of normally secreted sebaceous material and epithelial debris of the milk sinuses and thence to obstruction. Dilatation of the milk sinuses develops, creating a retention cyst of the milk sinus. Disruption of the sinus wall leads to extravasation of the irritating keratinous material into the subareolar fat and produces the subareolar inflammation and abscess. There is no proof, however, that nipple invagination definitely precedes the condition. The invagination may result from fibrosis and shortening of the diseased duct, drawing the nipple inward. Furthermore, the abnormally great extent of the squamous epithelium lining the duct is not fully explained in this manner.

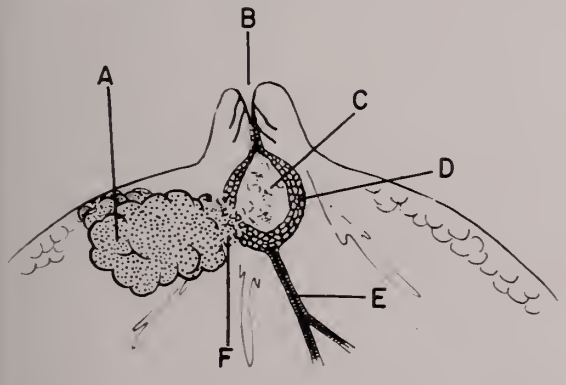
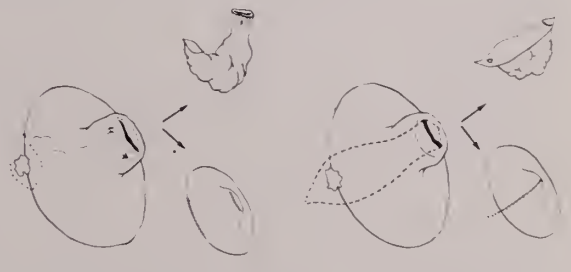


Fig. 5. — Diagrammatic illustration of subareolar breast abscess. A. Abscess cavity; B. Central invagination of nipple; C. Dilated duct filled with debris; D. Stratified squamous epithelial lining of the duct; E. Excretory duct; F. Point of disruption of duct wall and extravasation of duct contents.

Treatment

Successful eradication of recurrent subareolar abscess can only be brought about by excising the diseased duct or ducts lined by abnormal squamous epithelium, as well as the subareolar granuloma. Figure 6 illustrates two techniques for radical excision of the disease process. In both procedures, the entire extent of the diseased duct or ducts, from their orifice on the surface of the nipple out to the subareolar abscess, is excised. This procedure may lead to a flattened nipple without erectile power, but is generally considered by the patient to be a small price to pay for eradication of a most distressing, chronic problem.



A. Double Elliptical Excision B. Radial Excision

Fig. 6. — Basic surgical techniques for excision of subareolar granuloma and nipple ducts (A. Technique of David V. Habif, M.D.).

The excision should not be attempted in the acute phase of the disease. When the patient presents herself with a frank abscess, it should be drained surgically in the most simple way possible. When the acute infection has subsided, careful excision should be performed as an elective procedure.

Summary

The clinical and pathological features of recurrent subareolar abscess of the breast are described and the pathogenesis of this troublesome disease is discussed. The necessity for excision of the diseased ducts within the nipple itself is emphasized and two operative techniques are illustrated.

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Hallucinations In Adolescent and Preadolescent Children

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Twenty-eight patients were interviewed in a juvenile court psychiatric clinic. The clinical interviews revealed that 16 of these patients had auditory and/or visual hallucinations. An attempt was made to determine the significance of hallucinations in children. In examining the literature, it became apparent that there are conflicting viewpoints.

Sherman[9] set hallucinations apart from the more normal imagery of children and recognized them as a symptom of serious mental illness. Campbell[5] noted that although hallucinations may be described as hearing or seeing, the actual experience may be much different. The perception of an hallucination may be of a different quality than reality perceptions. He noted, "It is important to pay attention to the perceptual quality and the reality value of the hallucinatory factor." It was pointed out that even though the reality testing had diminished, there must be some intact reality testing to distinguish it from a real external stimulus.

Levin[7] spoke of hallucinations in "nonpsychotic" children. He acknowledged that some of his "nonpsychotic" children may have been psychotic. Particular attention was paid to the conflicting wishes that hallucinations may express. He related them to Bleuler's observation[3] that the roles of pro and con may be assumed by the hallucinations of adult schizophrenics. The difficulty with which patients differentiate between voices and thoughts is explained as a derivative of the undifferentiated stage of the individual in which the thought and the perception are unified. He observed this phenomenon in his cases and noted their similarity to Bleuler's cases, but still referred to the children as nonpsychotic. He also mentioned normal children hearing their own thoughts. This view is contrary to our observation.

Despert,[6] in her study of hallucinatory experiences in children, concluded that ". . . after examining the total records of 106 children (normal preschool) it can be emphatically stated that there is no evidence of true hallucinations or delusions either expressed by the children or observed by outsiders at home or at school." In a group of children with behavior or neurotic problems, a small number reported auditory hallucinations characterized by simplicity and singleness with the remainder of the personality untouched. She concluded that hallucinations and delusions experienced in the psychotic children above the 10 to 11 year level are similar to those in psychotic adults. It is important to differentiate the hallucinations of the schizophrenic child from the other hallucinatory phenomena such as hypnagogic and hypnopompic hallucinations, eidetic imagery, Isakower phenomena,[8] imaginary play objects, toxic organic hallucinations, and other hallucinoses such as those described by Brenner[4] and Weiner.[10] The

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The material for this paper was obtained with the assistance of Mario Ibanez, M.D., Director of the Dade County Juvenile Court Psychiatric Clinic, Miami.

hallucinations that were described by Bender[1] and Levin[7] do not appear clearly differentiated from schizophrenic hallucinations.

Interview Technique and Criteria for Diagnosis

The patients studied were those sent to the psychiatric clinic of the juvenile court at the discretion of juvenile probation officers and the juvenile court judge. The reasons why they were referred varied considerably from the opinion of the judge that the patient needed psychiatric aid to requests by the patients themselves. The patients were seen for as many 50 minute sessions as the examiner thought were indicated in a given case to make a diagnosis and to suggest a disposition. The number ranged from one to three sessions.

In addition to information obtained in the patient interview, a social history was available. This was obtained by the probation officer of the juvenile court. Although Levin[7] suggested that the direct inquiry for a history of hallucinations may elicit a spurious history by suggestion, we thought that, as in other medical histories, the symptom must be specifically inquired for if it is not related to the physician spontaneously. This information was generally elicited by assurance that such an admission did not always mean a serious illness, that if hallucinations had occurred and the doctor knew of it, he might have the means of helping the patient rid himself of them, and that the doctor knew of other children who had experienced hallucinations. The question was not asked unless some degree of rapport had been reached.

An opportunity was first given to allow the patient to relate spontaneously the desired information. Questions were evolved in specificity from, for example, "Have you had any strange experiences?", "Have you had any dreams or nightmares when really awake?", and, "Would you be afraid to tell me if you did hear a voice?" If a patient admitted to hearing voices or seeing visions, the symptom was not admitted to the history unless the patient was able to produce spontaneously a credible description of the experience. Inquiries were made into the direction the voice came from, the state of consciousness of the patient, the sex or identity of the voice, and whether the patient felt compelled by it or personally involved in it. Some of the patients who admitted to hallucinations were really admitting to hypnagogic phenomena or simply admitting hallucinations so as to please the examiner. Most of the interview time was used in exploring the present illness and mental status with major inquiry into the area of reality testing.

Report of Cases

Case 1.—A 12 year old Caucasian boy was referred to the Juvenile Court Psychiatric Clinic because of the alleged performance of sodomy on a boy two years younger than himself in the presence of a third boy. The patient was the "active" participant. The parents of the patient were living together and the father was regularly employed. The mother did not work. School progress had been average and he had never been a behavior problem in the classroom. In play he generally chose children younger than himself and had few friends in school of his age.

He was a small, thin boy who appeared several years younger than his stated age. His voice was high-pitched and showed little variation. He displayed little overt anxiety except for some restless movements of his hands. At times he seemed aloof and unconcerned. He denied the charges which led to his difficulty with the juvenile court, but unexpectedly told of being forced to perform fellatio under threat of a knife a year prior to his present difficulty. He showed little affect as he related this information. He readily admitted to auditory hallucinations when asked about any strange experiences. He noted that he had been having them for about a year, and he described them as sounding like an echo. The voices would usually call his name and were heard principally when he was alone. He denied that the voices were troublesome to him and seemed to accept them as part of his daily life. He became reticent when asked to enlarge further on the content of the auditory hallucinations. In general, the patient seemed withdrawn, uninterested, and with little appropriate affect. It was thought that he represented a severe emotional disturbance, probably of psychotic proportions. This conclusion was also supported by psychological testing.

Case 2.—A 14 year old Negro girl was referred because she presented a behavior problem at home and in school, frequently fighting and constantly arguing. She stated that she hated girls and wished she were a boy because "boys don't get into as much trouble," and she could "beat up" everybody if she were a boy; that if she had been a boy she would have been killed by this time because she would have "beat up" the wrong person. She expressed wishes that she were dead.

The patient was superficially cooperative, but verbalized hostile feelings without accompanying appropriate affect. Her affect was generally blunted. She stated that she had heard voices since she was small and that she had always felt different. The voices seemed real to her, came from outside her head, and frequently she felt compelled to do as the voices directed her. Nearly every feeling that she expressed was ambivalently countered by its opposite. She thought that her family was against her and that the neighbors talked about her.

In an interview with the mother in reference to some of the child's symptoms, she tended to consider that the child's auditory hallucinations were of no consequence because the mother herself had had similar experiences all of her life and did not consider them abnormal. Psychological examination of both the mother and the patient substantiated a diagnosis of schizophrenia.

Comment

Of the 16 children with hallucinations, 14 were thought to be schizophrenic. This number was out of an original sample of 28. We do not wish to imply that 50% of the children involved in juvenile court cases are psychotic. This is

obviously a higher incidence than would be expected. The assignment of patients was made according to clinic routine and not by the examiners. The cases in this series were not a sampling of juvenile court cases, but a sample of cases referred to the psychiatric clinic by the court probation officers and judges, or by request of the patients themselves. This method of referral may have contributed to a selection of more severely ill children. We are of the opinion that one reason for the high percentage of schizophrenic children was that an assiduous search for psychotic symptoms was carried out. Their occurrence was carefully, specifically, and as adroitly as possible determined.

Some physicians are reluctant to "brand" the patient by making a diagnosis of a psychosis or schizophrenia. This attitude is not in the best interest of the patient or of the study of psychiatry since proper diagnosis is a requisite to proper therapy. Some of these children may fall into Bender's category[2] of pseudopsychopathic schizophrenia, but an accurate developmental history was unavailable in many cases.

Summary

Twenty-eight patients were interviewed in a juvenile court psychiatric clinic. Of these, 16 had auditory and/or visual hallucinations. Various authors have reported varying significance to hallucinations in children from "normal" to "psychotic." We think that of these children with hallucinations in a clear sensorium, 14 were schizophrenic. In a few cases the patient with hallucinations did not manifest the criteria for a diagnosis of schizophrenia, and the hallucinations were not ongoing or clearly defined. The condition diagnosed as schizophrenia was not so diagnosed solely on the basis of hallucinations but on the presence of more fundamental disturbances of reality relationships, thought processes, and disturbances in affect. The diagnosis of schizophrenia is important to treatment. Similarities between these and classic descriptions of schizophrenia were noteworthy. Interview technique is discussed. The necessity for a thorough search for specific symptoms is emphasized. Two case histories are presented.

References are available from the authors upon request.

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Anterior Urethrovesical Vaginal Suspension

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The tubular portion of the urinary bladder[1] in the female has at least 60 surgical operations[2,3] to its credit for the control of urinary stress incontinence.[4,5,6] These have been devised since Kelly described his operation in 1913.[7] Thus, the importance of this structure is exemplified. The 16% early and 30% late failures[8] associated with such surgery per vaginum account for the constant search for better results. Suprapubically, a 10% failure rate exists.[9] Ball's combined abdominal-perineal operation[10] is highly successful with a 4% failure rate.

Add this to the 20 or more operations described for the correction of rectal prolapse,[11] and the importance of the pelvic relaxation syndrome[12,13] in the female is appreciated. Urinary incontinence, mechanical stress type,[14,17] is a symptom of this syndrome. The cystourethrocele, anterior and posterior,[18] and the rectocele are a part of this syndrome.[13] An attempt should be made to relieve each and all of the existing problems at one time.

The addition of another combination of procedures may seem redundant in view of these formidable facts, but such is offered because of the excellent results obtained, the ease of accomplishment, the lack of complications, and the patient satisfaction experienced in 21 cases.

Symptoms

The symptomatology involved besides mechanical stress incontinence includes a pelvic falling-out feeling, suprapubic pressure, a mass at the introitus, and a constant desire to urinate aggravated by the upright position and activity. Frequency of urination has often been noted. Many times frequent attacks of urinary infection (cystitis) are presented.[12,13,18]

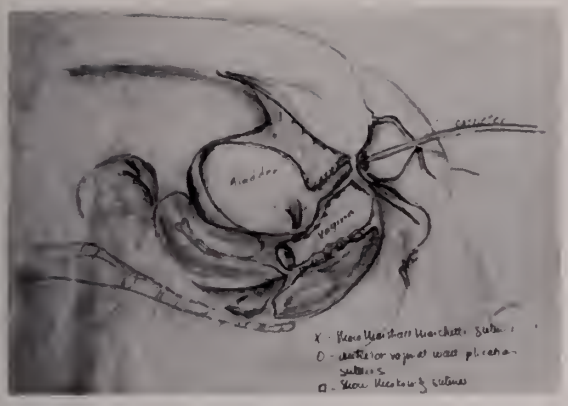


Figure 1

The small or moderate cystocele which seems such a simple lesion and so easy to correct, is really a lesion of unusual interest. There are important hidden features which require a long time to work out and which are still unappreciated by many operators. The troublesome symptoms of this type cystocele are largely those of mild bladder irritation—frequency, urgency, recurring desire to urinate and imperfect control. In many cases, these symptoms persist after operative correction of the vaginal cystocele. It was this persistence of symptoms which led to the prolonged study.[18]

These symptoms must be ferreted out from the patient by careful questioning. The recent embryological,[19-21] anatomical,[22-25] physiological,[22,26-30] pathological,[30,32] and radiological[33] studies more clearly explain these symptoms.

Surgical Procedures

The Marshall-Marchetti operation originally used for urinary retention,[34] and still used for select cases of retention in the female,[35-37] has its greatest usefulness in the control of mechanical stress incontinence in the female. It is a simple, direct, relatively minor technique fraught with few complications, correcting the existing pathological condition.[12,13,18] The operation has been used for recurrent stress incontinence following repairs from below,[34] developing after hysterectomy and conventional cystocele repair, in primary incontinence,[38] in selected cases of urinary retention in the female,[35-37] and prophylactically in conjunction with an abdominal hysterectomy.[38]

Since 1949, approximately 200 patients have been treated in this series. The 6% failure rate, partial, complete, or a recurrence, compares favorably with that of the Ball operation,[10] a combined abdominal-perineal procedure. Two additional patients were badly selected. One had porphyrinuria and the other was mentally deficient. In several of the earlier cases, the symptoms of pelvic relaxation disappeared as the incontinence was controlled. A study of the cases in which such symptoms persisted led to the conclusion that more than the anterior retropubic urethroplasty was required.

Preoperative evaluation of the patient included the usual history and physical examination with special care to bring out the pelvic symptoms mentioned. The pelvic examination was made with the patient in both the supine and erect positions. Catheterized urines were examined. If infection of the urine was present, it was adequately treated before the incontinence was evaluated. Cystoscopy and intravenous pyelograms were included both to observe the vesical neck function[13] and rule out contributing urinary pathological conditions. A cystometric examination[29,30] was made to rule out neurological pathological conditions. While the bladder was full, the degree of incontinence under stress was visually determined. Coughing, straining and squatting positions were employed to demonstrate this. Urethral length was measured by the Lapides technique,[22] and if the urethral length was below 3 cm. with incontinence, operation was performed.[22] Voiding cystograms, cineroentgenography,[33] and transducer urinary flow stud-

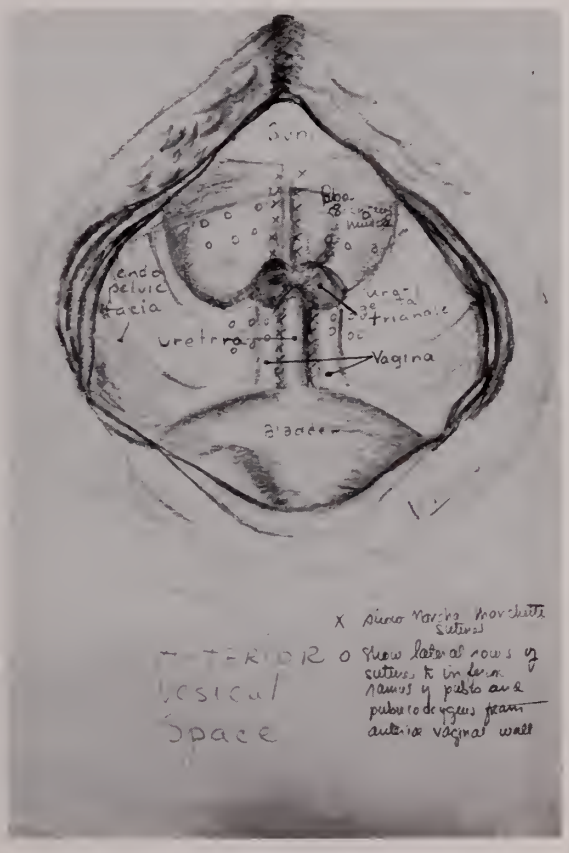


Figure 2

ies[33,39-41] were not employed. Urethral calibration was accomplished with acorn-tipped bougies and any stenosis was treated.[42] Estrogenic therapy[43] was employed in applicable cases of hypogonadism. Routine dilatations and silver nitrate installations are not useful in this problem. A bona fide stricture is treated accordingly. By personal communication, these therapeutic techniques have been described as a form of psychotherapy,[44] rubefacient,[45] or of no value.[46] Kegel's exercises[46,47] have been used only as an adjunct to other forms of therapy, but my results with them have been poor.

Preoperatively, the abdominal and genital skin is shaved. The patient receives an enema the night before, is allowed nothing by mouth after midnight and is given meperidine hydrochloride (Demerol) and atropine as premedication. A No. 20 French Foley catheter with a 5 cc. bag is placed indwelling per urethra immediately before the operation.

The operation is not difficult to accomplish. The usual suprapubic incision through skin, subcutaneous tissue and muscles is used. Bleeding is continuously controlled by hemostats and ligatures. The peritoneum is carefully opened after the retropubic space is dissected exposing the symphysis pubis, anterior vesical surface, bladder, urethra and vaginal surface. The rami of the pubis and pubococcygeus muscles are exposed bilaterally.

If a hysterectomy is to be performed, it is done at this point; if not, the bladder is carefully elevated from the vagina as far distal as possible. The peritoneal Moschcowitz operation[48] is then performed using interrupted No. 3 silk sutures. At this point, the peritoneum is closed. Next, the anterior suburethral vaginal plication[49] is done with interrupted sutures of the material mentioned. The number of plication sutures varies from four to eight. This procedure repairs the cystocele. The Weyrauch modification[35] of the Marshall-Marchetti operation[34] is then performed with two rows of sutures extending laterally along the inferior rami of the pubis at the junction with the pubococcygeus muscle. This may require three to four sutures on each side. While the Marshall-Marchetti operation (anterior urethrovesical suspension)[34] is being performed, the previously inserted catheter and the urethra are grasped with a Babcock forceps and held in place by cephalad traction assuring good urethral position. The wound is closed. No drains are employed.

Postoperative Care

Postoperative management consists of bed rest and catheter drainage for seven days. An antibiotic, usually chloramphenicol (Chloromycetin), 250 mg., three times daily, is given intramuscularly or orally for a five day period. Then a sulfonamide, 0.5 Gm., or nitrofuranton (Furadantin), 50 mg., four times daily, is substituted for the antibiotic. Bethanechol chloride (Urecholine), 10 mg., four times daily, is started on the fifth postoperative day. The catheter and sutures are removed on the seventh postoperative day. Ambulation is now permitted. After three spontaneous voidings, or attempts to void, the residual urine is measured by catheterization. If it exceeds 90 cc., the catheter is reinserted for two more days and the same procedure repeated. Discharge from the hospital is usually allowed on the eighth postoperative day. Two patients were discharged with indwelling catheters. These were removed one week later at the check-up office visit.

The results have been good. There was one failure. Specific antibiotic and chemotherapy treatment was employed until the urinary infection from the catheter was cleared. No fistulas or wound hernias were experienced in this series. One patient suffered osteitis pubis, but responded to steroid therapy.

Conclusion

A combination of operations is presented to control not only stress incontinence but also the whole pelvic relaxation syndrome with the exception of the rectocele. This is done both intraperitoneally and extraperitoneally through a suprapubic incision, in conjunction with or independent of a previous hysterectomy. The technique is easy to do. There is little blood loss. It is fraught with few complications and the results compare favorably with more extensive operations. Little morbidity and no vaginal drainage occur after discharge from the hospital.

References are available from the author upon request.

1801 North "E" Street.

Electromyography in the Evaluation Of Reflex Muscle Spasm

Simplified Method For Direct Evaluation of Muscle-Relaxant Drugs

Pedro Arroyo, Jr., M.D.
MIAMI

Quantitative measurement of involuntary muscle spasm has not been entirely satisfactory. Most studies have been performed in patients with spasticity due to upper motor neuron lesions. The evaluation of muscle-relaxant drugs in such patients has been difficult to interpret because of the many variables that affect the state of the spastic muscles at different times and under different conditions.

These variables have been found to be relatively insignificant in the muscle spasm present in the so-called fibrositic nodule or "trigger" area, in certain patients with nerve root pressure syndromes, cervical and low back strains, osteoarthritis and fibromyositis. The parameters of the muscle spasm in these areas are relatively constant over prolonged periods. With the patient relaxed in a resting position, they continue to exhibit spontaneous and prolonged firing of motor units as shown by electromyographic examination. It is thought that these "trigger" areas present nearly ideal regions for the evaluation of the effect of drugs on skeletal muscle spasm.

Electromyographic examination with a needle electrode in a normal muscle reveals that insertion of the needle results in a short burst of electrical potentials due to the momentary contraction of muscle fibers. Normally this lasts for a fraction of a second and then the sweep of the electron beam returns to the isoelectric line of electrical silence present in the normally relaxed or resting muscle. In patients with tender muscles, or increased muscle irritability, this electrical activity may last for one or two seconds. Deep palpation of these muscles will prolong this activity; however, it does not last long and the tracing returns to an isoelectric line in a few seconds.

In patients with fibrositic nodules, the insertion of a needle electrode into the nodule produces a continuous and prolonged burst of electrical activity. The electromyographic picture produced is similar to that of a normal voluntary muscle contraction of moderate degree (fig. 2). These nodules, relatively circumscribed areas of muscle spasm, varying in size from a few millimeters to almost three centimeters in diameter, appear in muscles which are otherwise relaxed. This finding can be demonstrated by the use of multichannel electromyography in which a second tracing is recorded from other parts of the same muscle where electrical silence is normally present. This observation also proves that these repetitive discharges are not the response of the irritable muscle to the presence of the needle, but represent true reflex muscle spasm.

The electrical activity produced by the spasm in these nodules is not abolished by the voluntary contraction of the antagonist muscles; however, when the area is injected with procaine, with the needle electrode left in place, the electrical activity rapidly subsides. This electrical activity is also abolished by spinal anesthesia. The substitution of procaine by saline will not reproduce these results. In cases where these nodules are secondary to nerve root irritation syndrome, as produced by herniated discs, the "trigger" areas will disappear following elimination of the cause. There seems to be little doubt, therefore, that these tender areas are the result of reflex muscle spasm arising from motor discharges in the anterior horn cells.

As an explanation, Travell, Rinzler and Herman[1] suggested that irritation of the nerve roots creates a stream of impulses that pass into the spinal cord and set up a state of excitability which influences the anterior horn cells to discharge. The resulting muscular contraction, if persistent, gives rise to pain and still more afferent impulses, thereby creating a vicious cycle of self-perpetuating spasm.

In 1944, Elliott[2,3] studied these areas of

Medical Director, Rehabilitation Center for Crippled Adults and Children, and Assistant Clinical Professor, University of Miami School of Medicine.



Fig. 1. — Patient relaxed with electrode needle inserted leading from two channel electromyograph equipped with camera and tape recorder.

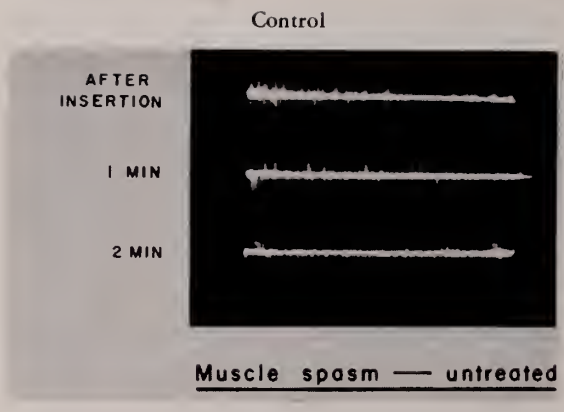


Figure 2.

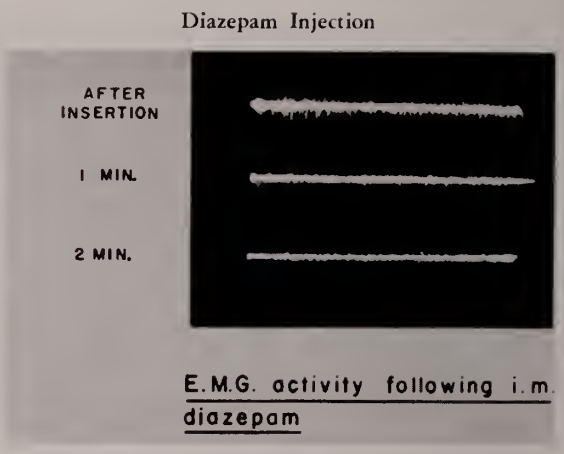


Figure 3.

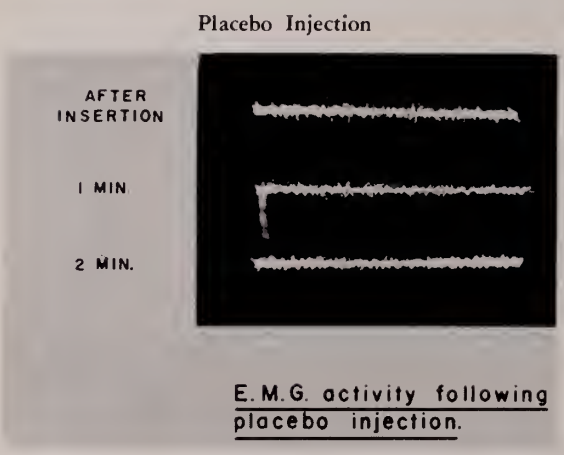


Figure 4.

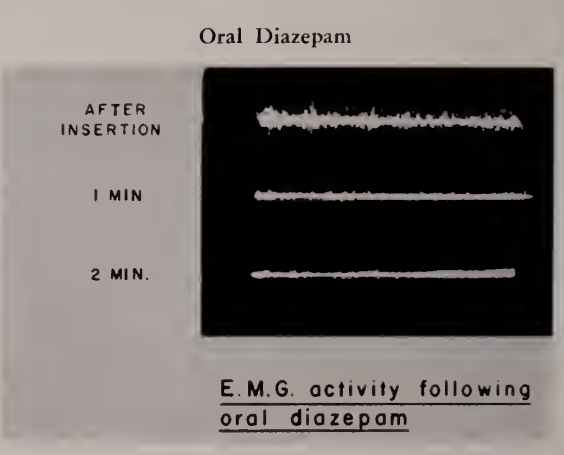


Figure 5.

Figs. 2-5. — Electromyograms of the effect of diazepam versus placebo upon reflex muscle spasm. First tracing in each myogram was recorded after electrode-needle insertion. Photographs were taken, using triple exposures, by electrically shifting the oscilloscope baseline.

spasm and observed a reduction in blood flow. By the use of thermoelectric methods with needle electrodes, he also noted that these areas of muscle spasm are "cooler" than normal adjacent areas. He thought that excessively prolonged muscle spasm may prove a source of trophic changes in the tissues and a source of irritation producing pain which might be similar to that occurring in claudication. Any discussion as to the actual cause of these tender areas is still largely speculative; however, it was thought that these areas of reflex muscle spasm provided excellent mediums for evaluating the effect of drugs on reflex muscle spasm.

Evaluation of Diazepam as a Muscle Relaxant

The effect of diazepam*—a psychotherapeutic drug of the benzodiazepine class—and a placebo on the reflex muscle spasm was evaluated in 20 patients. Each subject presented fibrositic nodules secondary to nerve root pressure syndromes, cervical or low back strains, or fibromyositis.

Method. — Electromyographic studies were performed using a two channel Teca electromyograph equipped with a Polaroid camera and a tape recorder. Needle electrodes were used, since surface electrodes proved to be of relatively no value in localizing areas of spasm which, at times, were deep in the paravertebral musculature. The patients were examined in the prone position and in a relaxed state (fig. 1). The tender areas in the back were explored with a coaxial needle electrode for areas of muscle spasm. Tape recordings were made of the electromyographic tracings. When an area of muscular spasm revealed prolonged electrical activity, the needle was left in place and a photograph of the tracing was taken, and again taken one and two minutes later (fig. 2).

Results.—With the needle still in place, 5 mg. of diazepam was injected intramuscularly into the gluteal region. After 15 to 20 minutes, the electrical activity in these areas of spasm diminished, or completely disappeared in all cases. At this time when there was little or no muscle spasm, the needle was again moved within the fibrositic nodule, with care being taken to keep the needle in the same general area. This procedure was accomplished by moving the needle in and out for only a few millimeters. Another picture was then taken, and this maneuver resulted in a brief burst of electrical activity which lasted for only a few seconds. The needle again was left in place and pictures were taken one and two minutes later. In all cases tested, marked reduction of electrical activity was manifested by a lesser number of motor unit discharges and lower voltage (fig. 3).

When the patients were given 1 cc. of placebo intramuscularly, no significant change in the electrical activity was observed for periods up to one hour (fig. 4). One patient remained in the same position for one hour without any significant changes in the electromyographic pattern in spite of the fact that the patient reported giddiness and drowsiness as a result of the injected placebo.

Following the electromyographic studies with intramuscular administration, patients were given oral diazepam, in doses of 2 mg. three times a day for one week. Electromyographic tracings at the end of the week demonstrated approximately the same results as obtained following parenteral administration of the drug (fig. 5). The patients' subjective responses in general related well to the electromyographic findings. They reported a decrease in tenderness of the affected muscles and greater mobility. No significant side effects were noticed during this study.

It is concluded that this simple method provides an objective quantitative measurement which gives consistent results in the evaluation of the effects of drugs on reflex muscle spasm.

Summary

A simple electromyographic method, employing a needle electrode, which yields quantitative measurements of reflex muscle spasm is described. Its usefulness in the evaluation of muscle-relaxant drugs is demonstrated in 20 patients with muscle spasm due to nerve-root pressure syndromes, cervical or low back pain, or fibromyositis. Electromyograms show the effect of diazepam (Valium) versus that of a placebo upon reflex muscle spasm.

In contrast with control tracings and those recorded following placebo injection, diazepam (administered both parenterally and orally) in all cases produced marked reductions of electrical activity in the affected muscles as manifested by fewer motor unit discharges and lower voltage. Patients' subjective responses were decreased pain-spasm and increased mobility of the involved muscle groups, which correlated well with the electromyographic evidence of muscle relaxation.

References are available from the author upon request.

1475 Northwest Fourteenth Avenue.

*Valium, Roche Laboratories, Nutley, N. J. 07110.

Symposium on Trauma



The Reconstructive Surgeon's Role in the Treatment of Trauma

D. Ralph Millard Jr., M.D.
MIAMI

Plastic surgery got its early start in the problems of trauma and made its greatest advancements in the midst of carnage. Thousands of years B.C. were the Indian mutilations and the forehead rhinoplasty. Then came the dueling injuries of sixteenth century Europe treated with the arm flap, and the great surge in all phases of repair during World War I and II.

Contributions to the Treatment of Trauma

1. Initial Repair

When the condition of the patient permits, meticulous initial repair offers the best chance for return to normal. Gentle approximation of all tissues, bone, vessels, nerves and skin, using known points for accurate repositioning, is fundamental.

2. Improve Standards

By refining general techniques there has been a contribution toward raising surgical standards so that better scars are produced and placed in less noticeable positions. Stitch marks are avoided. Quicker and better cover is supplied not only as split grafts to burns but by the use of local and distant full thickness tissue for improved texture and color match as well as the prevention of contracture.

3. Grafting Amputated Parts

Replacement by autografting of amputated parts, an ear, a nose, a lip, an eyelid, can best be accomplished by the plastic surgeon. On the same principle he should be a member of any limb replacement team.

4. Assist Other Specialists

The ability to shift covering tissue can be a benefit to other specialists facing large or troublesome defects. A scalp rotation flap well planned may prevent a neurosurgical disaster. An immediate crossleg flap will assist the orthopedic surgeon to avoid an osteomyelitis or a nonunion. The shifting of a large abdominal flap in an avulsion-evisceration, if correctly designed, could be lifesaving.

5. Techniques Useful

In those communities where no reconstructive surgeon is available, plastic surgical principles and techniques that have been developed and reported in the literature can be of great value to the general surgeon. Some of these will be discussed by the following panelists on the subjects of soft tissue repair, facial fractures and immediate crosslimb flaps.

6. Invaluable for Secondary Work

Although the best final result following trauma is influenced by the initial repair, secondary work by a reconstructive surgeon can make up for inadequacies or impossibilities present during the emergency. The optimum time for secondary work may vary from six months or more in skin scars to as soon as the swelling has subsided for distorted facial fractures or diplopia.

Read before the Florida Medical Association, Ninety-First Annual Meeting, Miami Beach, April 23, 1965.

2121 Biscayne Boulevard.

Immediate Care of Soft Tissue

JOHN M. HAMILTON, M.D.
ST. PETERSBURG

Proper handling of soft tissue wounds is important for the return of optimal function and because the skin and underlying soft tissue are the part that is visible to the patient for the rest of his life. While the primary purpose in repair of soft tissue wounds is the return of function, the appearance of the exposed scars, especially of the face, is almost of equal importance. The inevitable scar tissue that follows a disruptive wound is the enemy of the reconstructive surgeon and the following are some of the principles used to minimize scar formation.

Time of Repair

With few exceptions the best results can be obtained by immediate repair. This prevents the formation of hematoma, infection, and granulation tissue, all of which add to scar formation. All raw surfaces should be closed by direct suture, mobilization of local pedicle flaps, or skin graft. Where tissue is missing, either a primary resurfacing or anatomical closure is necessary.

Anesthesia

Most soft tissue repairs can be made with local anesthesia using local infiltration of dilute local anesthetic or regional nerve blocks. I usually anesthetize the wound before final cleansing, palpation and removal of foreign bodies. This plan allows a more thorough examination and cleansing of the wound and gives ample time for good anesthesia before starting the repair.

Hemostasis

As soon as the wound is anesthetized and well cleansed, all bleeders are clamped and tied with fine catgut ligatures. A thoroughly dry wound is necessary for accurate approximation of the various disrupted structures and layers.

Debridement

A minimal debridement is usually carried out to remove contaminated tissue, "ground in" foreign bodies, and irregular devascularized tissue which would detract from the final hairline scar. Too much debridement might cause wound tension or loss of contour. Sometimes the direction of the wound can be changed so that it will fall into the normal skin creases, or a Z-plasty might be used to prevent future scar contracture.

Wound Closure

The important structures such as nerves, muscles, tendons, and occasionally blood vessels are



Fig. 1. — A. Extensive windshield injury disrupting lacrymal apparatus, ear canal, and middle branch of facial nerve. B. Same patient after initial repair only.

Read before the Florida Medical Association, Ninety-First Annual Meeting, Miami Beach, April 23, 1965.



Fig. 2. — A. Shotgun wound of face with extensive disruption. B. Patient after initial repair with good salvage of bones and soft tissues.

first repaired according to the usual techniques of these structures. Occasionally a wound must be extended or other incisions made to identify fully and repair these structures. These extensions or incisions should follow the normal skin creases as much as possible to minimize the final scars and prevent scar contractures. The wounds are then fitted together and carefully closed in layers using small usually absorbable sutures which accurately approximate the deep layers and obliterate all dead space (figs. 1 and 2). The skin margins are then sometimes undermined slightly and are closed with an inverted dermis suture which closes the skin fairly accurately and removes all tension from the skin. This dermis suture is placed so that the knots are buried deeply. The skin suture is of fine closely spaced marginal or subcuticular sutures which only "dress up" the skin margins to give a very accurate closure without inversion of the skin margins. It is usually necessary to take equal-sized sutures in each skin margin to obtain this result. Where tissue is missing it may be necessary to use local flaps to close a wound in a more anatomical repair without tension. Closure of large defects may require skin grafts to obtain a complete wound closure without remaining raw surfaces. Sometimes it is wiser to close skin to mucosa and repair the resulting defect at a secondary procedure.

Dressings

There is no field of surgery where the application of the dressing is more important than in reconstructive surgery. A good dressing should immobilize the wound and apply gentle, even pressure to retard edema, dead space, hematoma, or infection. The first dressing can usually be removed in 48 to 72 hours and a smaller dressing be applied. Some antibiotic, nonmacerating ointment is usually applied to the suture lines so that the dressing can be gently changed without disturbing the wound. Sutures can be removed early to prevent suture marks as the wounds are closed without tension and a collodion or Micropore tape splint can be substituted until the scars become strong and lose their tendency to spread.

424 Beach Drive, N.E.

Values of Immediate Flap Repair in Extremity Injuries

Leo H. Wilson Jr., M.D.
SARASOTA

Cross limb flaps are a means of transporting full thickness skin and subcutaneous tissues directly from one limb to another. The crossfinger flap, the smallest, and the crossleg flap, the largest, by their immediate application provide many advantages through a quality coverage plus an economy in time required for repair. Flap repair not only physically closes portals of entry to infection but, by the use of vital tissues, supplies the important elements of fixed tissue immunity and circulating antibodies. This desirable superiority over the free skin graft is further enhanced by the ability to circulate antibiotics to the wound. Good padding protects sensitive bone and provides a yielding tissue for the absorption of otherwise disruptive trauma. Furthermore, because of padding, nerve endings are more likely to rest in subcutaneous adipose tissue and are less likely to be encased within a dense cicatrix, a condition predisposing to painful neuroma formation.

Whether it be an amputated digit or an avulsion of tissue overlying a tibial fracture, considerable morbidity will be the result and much time will be involved before any type of repair is complete. An immediate flap obviously will save each day of delay permitted by deferring indicated application. This economy in repair time can be measured by many values aside from the dollars and cents of medical costs—by early return to gainful employment, fewer operative procedures, less fibrosis of the wound, and less intense, less chronic, psychological adjustments.

Crossfinger Flaps

In addition to those general benefits of flaps previously noted, the crossfinger flap provides a means of preserving all remaining digital length following amputation. Amputation of additional bone of a phalanx to effect wound closure, particularly in a child, is grossly wasteful and this situation strongly demands the use of a crossfinger flap. Functionally speaking, this is a vital concern related to the thumb. It is especially significant in reference to the index finger where reduction in length greater than one third results in loss of dominance in concerted actions with the thumb, since the longer more useful long finger takes over oppositional and pincer activity and renders the index finger redundant. Psychologically speaking, preservation of phalangeal length and contour so as to provide a matrix bed for the intact nail base situated just proximal to a level of amputation has immeasurable value in maintaining normal body image—an importance sometimes of relatively great magnitude for such a small defect. The fully developed nail not only camouflages contour deficiencies but also provides protective cover for the dorsum of the transplanted tissues (fig. 1).

There are inviolate contraindications, however, for the use of the crossfinger flaps in certain young adults and in some older patients with collagen and vascular disease states, such as scleroderma, arthritis, arteriosclerosis, and Raynaud's phenomenon. Physiological state and not chronological age of hands should be the guide to the selection of crossfinger flap candidates beyond the age of childhood (fig. 2).

Technical Details

In crossfinger flaps, dorsal infiltration at the level of the metacarpophalangeal joints and digital nerve blocks performed in the palm at the distal crease using lidocaine (Xylocaine) solution containing epinephrine provide sustained anesthesia without fear of circulatory injury to both donor and recipient fingers, which are simultaneously anesthetized at the level of this nerve bifurcation.

Read before the Florida Medical Association, Ninety-First Annual Meeting, Miami Beach, April 23, 1965.



Fig. 1. — Amputation of index finger at level of distal joint. Soft tissues tapered for better functional and cosmetic result. No bone shortening. Crossfinger flap applied. Maximum digit length preserved. Vital two-thirds length of index finger prevents long finger take-over of oppositional and pincer action.

Maximum width in flap design is safely determined by a line drawn along the dorsal tips of the lateral flexion joint crease lines. Maximum flap length is limited by proximal and distal joint crease lines overlying the corresponding joint edges. Flap location is altered to permit donor and recipient digits to rest in a position of function during the three week period of immobilization required before pedicle severance.

Crossfinger flaps are elevated with the full subcutaneous layer of adipose tissue included, leaving the areolar tissue overlying extensor tendon to receive a full thickness skin graft transferred from the antecubital fossa.

Plaster fixation is avoided and the hand is elevated in the position of function. Fluff gauze dressings are changed and the fingers are passively exercised at weekly intervals (fig. 3).

Crossarm to finger flaps are useful in injuries involving multiple digital injuries.

Crossleg Flaps

Immediate crossleg flaps for complicated trauma requiring specific bone care are best performed as a combined orthopedic-plastic surgical simultaneous endeavor. In this fashion, both general and spinal anesthesia time can be held to a minimum during a procedure which would otherwise be lengthy.

Flap contributions to wound healing enumerated for the crossfinger flap apply equally to the crossleg flap. Where indicated, immediate repair offers even greater opportunity for time economy.

Fears of damage by infection to the sound limb, a deterrent in the minds of some when an immediate crossleg flap is under consideration, can largely be dispelled by adapting techniques developed through recent investigative work by Dr. Edward Compere in the orthopedic management of chronic osteomyelitis. This method, following excision of sinus tracts and necrotic bone, requires a tight wound closure with through-and-through irrigation by the use of input and output plastic tubes transporting antibiotics whose actions are potentiated, in effect, by detergent solutions (for example), Allevaire, and has resulted in a series of cases with remarkably fine results. To the well recognized value of suction in minimizing serum



1



4



2



5



3



6

Fig. 2. — Sixty year old hand, yet physiologically young. Avulsion of soft tissue, flexor surface. Nail bed, phalanx, profundus tendon intact. Contour and function restored by crossfinger flap. No structures sacrificed in closure.

and blood collections beneath a flap overlying a fresh fracture site, can be added the security offered by a pre-positioned input tube for antibiotic-detergent solution irrigations should the need to combat infection develop.

Technique

The crossleg flap should be sutured snugly but without tension with the irrigation tubes introduced through stab wounds at a distance and tunneled to rest centrally beneath the flap, adjacent to the fracture site (fig. 4).

Every effort is made to achieve well padded fixation without resorting to the use of plaster casts. Posterior splints, overhead frames with trapezes, and extremity suspension leave the patient in a much more comfortable position during immobilization (fig. 5).



Fig. 3. — Tangential thumb distal phalanx amputation. End result illustrating repaired thumb and healed donor area on index finger repaired with full thickness skin graft.

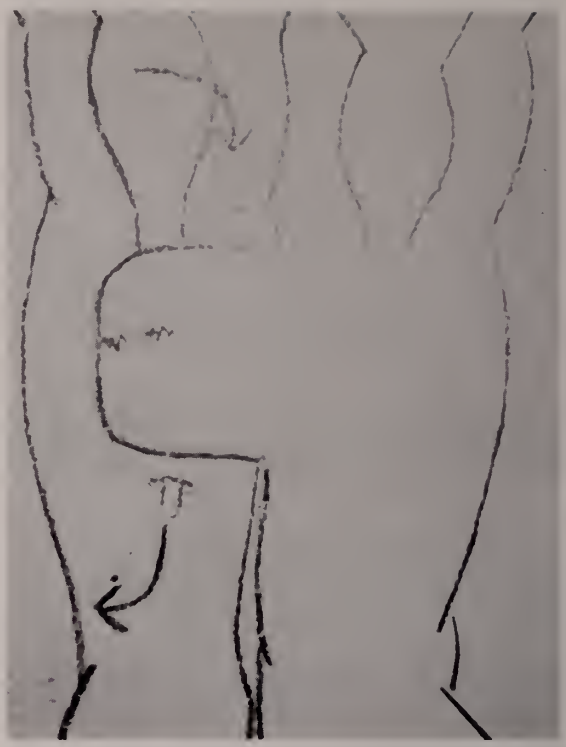


Fig. 4. — Diagrammatic representation of immediate crossleg flap with input and output irrigation tubes positioned through stab wounds at distance.

Summary

When one compares the many inherent values of flap repair with the simple dressing of the wound or with a split skin graft closure, it is apparent that the immediate application of flaps in indicated extremity injuries offers many more functional and psychological advantages to the patient and provides effective prophylaxis against infection. The use of the crossfinger flap as a substitute for the needless sacrifice of digit length is encouraged. A combination orthopedic-plastic surgery team approach to the management of complicated lower extremity injuries necessitating a crossleg flap is advocated.

202 Doctors Gardens Building.



1



2



3



4



5

Fig. 5. — Direct flap applied to defect overlying exposed metatarsophalangeal joint. No plaster fixation. Extremity suspension employed.

President's Page

Topsy Comes of Age

After World War II it became obvious that most counties were not adequately fulfilling their constitutional responsibility to provide health care for the needy sick. Institutional care provided in charity hospitals was usually of poor quality and costly. Imposing on voluntary health facilities to provide for the indigent without reimbursement was a common practice which, in effect, taxed the paying patient and hampered development of health facilities.

In 1955 we established a demonstration project under Florida Statute 401 to show how a state plan could aid the counties in providing adequate health care for the needy sick. Although the law was adequate, the state appropriation never was sufficient to permit proper development of the program.

In 1960, the federal government offered financial aid for state medical assistance programs through the Kerr-Mills law which permitted compensation to vendors of health services to those eligible for tax-supported health care.

At the outset, welfare officials believed health care for welfare recipients should be administered within the welfare system and apart from the regular method of providing health care. The medical profession was not inclined to encourage that concept. Welfare medical programs, therefore, have grown like Topsy, uncoordinated and variously administered.

Topsy is a big girl now, and through Title XIX of Public Law 89-97, her guardians are ready to provide a place for her in the regular channels of medical care by adequately compensating the vendors of services.

The medical profession, I believe, is ready to provide medical services in a more organized manner. Implementation of Title XIX through the insurance carriers of Title XVIII A and B provides a convenient and logical method of accomplishing the objective of adequate tax-supported health care for those in financial need.

Payment available to physicians under the provisions of Title XIX, for medical services rendered welfare recipients and the needy sick, may be used by physicians to insure continuation of the system of individual personal medical care.

The danger of Title XIX is future elevation of financial eligibility for tax-supported care to unrealistic levels. Inadequate implementation of Title XIX, however, would inevitably lead to extension of Title XVIII A (Social Security Tax supported hospital care) which would produce a system of institutional medical care that has been proved repeatedly to be a high cost low production method of providing health services.

H. Phillip Hampton



Coordinated Effort in Postgraduate Medical Education

Two primary functions of a state medical journal are to further all continuing educational efforts and to serve as a medium for dissemination of knowledge of the state medical schools. These two functions are frequently best served together.

The population of Florida—total and physician—places us in the top 10 states. With this recent rapid growth has come a renewed effort by individual groups and educational institutions to sponsor seminars and meetings as each tries to improve the scientific atmosphere in which we work. These individual efforts have resulted in an overlapping of programs and duplication of subject presentation with a real waste of available speakers through lack of knowledge of their availability. This practice is wasteful financially and scientifically.

Eight years ago the Scientific Council of the Florida Medical Association, with the cooperation of The Journal of the Florida Medical Association, began a file on such meetings and speakers. A form was devised (form 1) enabling each group presenting a program to apply to the Committee on Postgraduate Education for a specific type of state association participation. Once approved, the meeting date and subject are carried in the news column of The Journal once and in a list of meetings each month until the meeting date, thus giving publicity to the effort. Following the meeting, a second form (form 2) is forwarded to the sponsoring group requesting information so that a permanent file as to attendance, subject preference and speaker appeal can be available. The forms are reproduced at the end of this editorial.

The Florida Medical Association office now has this registry for all to use. To date not one group has consulted this file.

The Journal continues to print a list of all such group meetings for the benefit of our physicians and to enable each group planning a meeting to know what is going on in other areas of the state. Few sponsoring groups have consulted this listing before their plans have proceeded so far along that only regret is possible if meeting times overlap and speakers' subjects are duplicated.

Thomas Bartley, M.D., has recently been appointed Assistant Dean of the University of Florida College of Medicine with postgraduate education as his primary responsibility. Hayden C. Nicholson, M.D., Dean of the University of Miami School of Medicine, is making every effort to increase the continuing education offered to the Florida physician. James J. DeVito, M.D., chairman of the Committee on Postgraduate Education of the Florida Medical Association, and Richard C. Dever, M.D., chairman of the Scientific Council of the Florida Medical Association, are laboring to improve our town and gown communications. They recognize the need for a coordinated effort to present timely subjects by interesting speakers in needed locations.

In a letter to the Editor on page 43 of this issue Dr. DeVito presents the views of the Committee.

In our deliberations on this subject, The Journal believes it essential that a central source of information concerning these matters be used so that all physicians and groups planning a scientific presentation may clear time, subject and speaker prior to final decision. The Florida Medical Association Committee on Postgraduate Education at present has an established file, a procedure means and the administrative personnel to provide this function and this source seems to be the logical choice. Once known, the meeting date, speakers and subject will be carried in the meeting column of The Journal each month. Ideally, when known, this listing should cover all meetings for the coming year. A listing of visiting professors speaking in our medical schools will also appear

each month giving others an opportunity to arrange a local appearance of these speakers if it is impossible for them to attend the university program.

At this time a method is available to help us avoid past errors. This system will work, saving money and energy for all, if each of us will use the information available in our FMA headquarters and if we will cooperate with the Committee on Postgraduate Education of the Florida Medical Association by making this Committee a part of our individual scientific presentation planning committee.

T. M.

Form 1
FLORIDA MEDICAL ASSOCIATION
P.O. BOX 2411
JACKSONVILLE 3, FLORIDA

TO: FMA Committee on Postgraduate Education
FROM: Name
Address
Organization
SUBJECT: Request for Approval or Co-Sponsorship of Postgraduate Medical Education by the Florida Medical Association.*

The _____ requests (approval) (co-sponsorship) of postgraduate medical education to be conducted as follows:

1. Name of Course or Seminar etc.
2. Date(s)
3. Place
4. Subjects and Speakers
(Please note
speaker's principal
appointment)
5. Financial liability of FMA (if applicable) $
6. Other organizations whose approval or co-sponsorship is being requested
7. Program Chairman

*Criteria attached

8. Similar course held in previous years Yes_____ No_____
If yes, state years
9. Invitations to attend extended to:
A.
B. Particular field or specialty

Signed_____

Request granted for _____, date
by _____, Chairman, FMA Committee on Postgraduate Education.
Recommendation of FMA Postgraduate Education Committee approved by Executive Committee (if applicable).
Date_____ By_____
Cleared for conflicts (date)_____ By_____
Posted in FMA Registry (date)_____
Forwarded to FMA Journal (date)_____
Follow Up Questionnaire (date)_____

CRITERIA FOR APPROVAL, CO-SPONSORSHIP OR SPONSORSHIP OF POSTGRADUATE MEDICAL EDUCATION BY THE FLORIDA MEDICAL ASSOCIATION

I. APPROVAL of postgraduate medical education by the FMA will be granted through the Committee on Postgraduate Education, when in the opinion of the Committee:
   A. The organization sponsoring is creditable.
   B. The program would be of educational benefit to the members of the FMA.
   C. No financial or legal liability is assumed by the FMA.

II. CO-SPONSORSHIP of postgraduate medical education by the FMA will be granted by the Executive Committee upon the positive recommendation of the Committee on Postgraduate Education, when in the opinion of the Committee:
   A. The organization co-sponsoring is creditable.
   B. The program would be of direct educational benefit to members of the FMA.
   C. Definite financial liability is agreed upon and approved by the Executive Committee, or no financial liability is assumed.
   D. The speakers and their subjects are approved by the Committee on Postgraduate Education or its representatives (other FMA members only).

III. SPONSORSHIP of postgraduate medical education will be conducted by the Committee on Postgraduate Education (other than FMA annual meeting) for the FMA, when:
   A. Approval has been granted by the Executive Committee.
   B. Approval of the expenditure of funds has been granted (if applicable).
   C. The Association has direct control of all finances.
   D. The Association has direct control of the speakers invited.
   E. The Association has direct control of the subject matter.
   F. There is an educational need of the membership for the postgraduate education sponsored.

Form 2
FLORIDA MEDICAL ASSOCIATION
P. O. Box 2411
Jacksonville 3, Florida

TO: Committee on Postgraduate Education, Florida Medical Association
FROM: Name
Address
Organization
SUBJECT: Follow-up on Postgraduate Medical Education

1. Name of Course, Seminar, etc.
Date(s)_____ Place
2. Evaluation of Course, Seminar, etc.:
Attendance
Meeting place: Was it adequate?_____ How large a meeting should be directed here?
Services, i.e., hotels, entertainment, etc.
Speaker(s)
Subject(s)
Were factors such as time of year, weather, choice of subject, meeting place, advance notification of any effect on success of course, seminar, etc.?
3. Will Course, Seminar, etc., be offered next year?
Please give dates and place
4. In what manner may Florida Medical Association be of assistance?

University Role in Postgraduate Medical Education

Recently I have been appointed Director of Postgraduate Medical Education at the University of Florida College of Medicine. Dr. Suter, Dean of the College of Medicine, and I are agreed that as a state university we have a responsibility to assist in keeping the physicians of the state abreast of the rapid increases in medical and scientific knowledge of all types.

To carry out this responsibility to the best of our ability, we need the cooperation, participation, assistance, and criticism of all physicians and all elements of organized medicine. This includes the Florida Medical Association and its component parts and all of the specialty organizations interested in continuing education.

Our faculty is small, and their energies and time are in many cases already used to the utmost. To fill our role in providing continuing education and yet utilize our faculty as economically as possible, we will have to make use of telephone conference calls, television, and radio as well as seminar programs in Gainesville, and participation in intern-resident teaching programs in other cities of the state. Also, a subject-oriented program in depth is being planned for Florida physicians in conjunction with the University of Miami School of Medicine.

As I have told many of you personally, ours is a new school and we are particularly new and inexpert in the field of postgraduate medical education. We will have to try new methods as well as accepted ones to find the most effective way to do the best job possible in this field.

Thomas D. Bartley, M.D., Assistant Dean
for Postgraduate Medical Education
College of Medicine
University of Florida
Gainesville

Letters

October 21, 1965

Dear Dr. Moseley:

I am, at present, working my second term of office as Chairman of the Postgraduate Education Committee of the Florida Medical Association. It certainly has been an interesting and edifying experience for me and I am hoping to carry on the good work of Dr. Charles Collins who preceded my tenure. Every conscientious physician is well aware of the tremendous progress in the field of medicine today and the difficulty of the busy practitioner in keeping up with current advances, both in diagnostic techniques and therapeutics. Every state in the Union is making tremendous efforts to project continuing education programs through their physicians to maintain the practice of medicine at the highest possible level, at the most remote areas of their respective states. Florida is no exception. Our medical schools and larger clinics are constantly supporting postgraduate courses for varying lengths of time covering every possible field of medicine. Because of the paucity of postgraduate courses, there is a great deal of overlapping, not only from the medical centers and the larger clinics around the state but also the national societies and specialty groups who constantly promote and present continuing education studies at various levels almost constantly throughout the year. Because of the varied, desirable facilities that Florida has to offer, climate, recreational facilities, large hotels and year round outdoor activities, many of the larger medical organizations usually pick our state, as a preferred area in which to hold their seminars and conferences. It is therefore quite bewildering to the practitioners as to which course to take and when with the consequence that attendance is quite poor at many of these conferences.

It has been our thought that a central booking of seminars, possibly utilizing The Journal as a

(Continued on page 48)


Flagyl destroys trichomonads
here & here & here & here
No topical treatment can

Flagyl®
brand of
metronidazole

Flagyl eliminates the difficulties and frustrations that have long attended the treatment of trichomonal infection.

These difficulties arose mainly from:

1) the failure of any previously known agent to destroy the protozoan in paravaginal crypts and glands;

2) the failure of any previously known agent to prevent reinfection by eradicating the disease in male consorts.

The introduction of Flagyl removed both of these long-standing deficiencies. Hundreds of published investigations in thousands of patients have confirmed the ability of Flagyl to cure trichomoniasis.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced a cure rate of up to 100 per cent in large series of patients.

Nothing cures trichomoniasis like Flagyl.

Dosage and Administration

In *women:* one 250-mg. oral tablet t.i.d. for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When the inserts are used one vaginal insert should be placed high in the vaginal vault each day for ten days, and concurrently two oral tablets should be taken daily.

In *men:* in whom trichomonads have been demonstrated, one 250-mg. oral tablet b.i.d. for ten days.

Contraindications

Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precautions and Side Effects

Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

Dosage Forms

Oral–250-mg.tablets/Vaginal–500-mg.inserts

SEARLE

Research in the Service of Medicine

Association News

Conference of Presidents and Secretaries

The Association's Eighth Annual Conference of County Medical Society Presidents and Secretaries will be held Saturday afternoon and Sunday morning, January 29-30 at the Robert Meyer Motor Inn, Orlando. According to President Dr. H. Phillip Hampton, the purpose of the session, as in previous years, will be to help orient incoming county society officers regarding national and state programs, policies and activities of medical interest. The local society leaders also will discuss together some of their unique problems.

The following main subjects have been selected for special attention:

*The national medical scene: current American Medical Association activities.

*Social Security Amendments of 1965 (P.L.89-97) and its various provisions.

*Heart Disease, Cancer and Stroke Amendments of 1965 (P.L. 89-239).

*Development of the "Prevailing Fee" concept.

*Economic Opportunity Act, including Project Headstart and other programs with medical interest.

*The National Commission on Community Health Services.

*FMA scientific activities.

*Professional liability and other FMA insurance programs.

*Open discussion of county society problems and activities.

A good attendance is expected at the popular conference, at which better than 90% of the Association's membership usually is represented by the officers attending. Invited to attend and participate are all local society presidents, secretaries, executive personnel and other officers each society chooses to include.

Examination of Minors by a Physician: Legal Opinion

In Florida both males and females are minors until the age of 21 years. If, however, a minor marries, this relationship, by statute, confers upon either a male or female person the right to assume the management of his estate, contract and be contracted with, sue and be sued, and to do and perform any and all acts, matters and things that could be done if such person were 21 years of age.

As a minor, a person under 21 years of age and who has not been married, cannot contract, a physician should obtain permission from such minor's parent, the father, if living, and if not, the mother, for authority to render medical treatment to such minor, particularly surgical treatment. In an emergency a physician would be protected in treating a minor until such consent from the parent is obtained. If no parent is available, but a minor has a guardian, then the consent of the guardian should be obtained.

Florida has no statute which permits a physician to refuse to disclose, under proper procedures, information obtained through his relationship as a physician with his patient. Some states do have a statute. In Florida, a physician can, with the consent of an adult, disclose such information; and must, under judicial procedures, disclose information when required so to do in court or by an administrative board. The physician should not disclose information voluntarily.

When a physician examines and treats a minor female without obtaining the authorization from the parent or guardian, may the physician legally disclose the information obtained from the minor patient to the parents? To put it differently, must the physician disclose the information obtained to the parents, even without the consent of the minor patient? While each situation must be dealt with on the facts then involved, it is our opinion that the physician cannot disclose voluntarily information to the parents, particularly when objection is made by the minor patient. He can be required to disclose by appropriate procedures.

For the physician to be liable in damages, his act must be the proximate cause of the result sued for. It does not appear reasonable to assume that difficulties encountered by the minor because of the condition found by the physician can be attributed to his performance of his legal duty in withholding information not authorized to be disclosed by the patient.

Finally, as to the examination of students whose parents are not readily available for permission, it is our opinion that examinations or treatment should not be made by the physician, except in an emergency situation, or in a routine examination required such as for admission to an institution of learning.

Marks, Gray, Yates, Conroy & Gibbs
Legal Counsel, Florida Medical Association

News

The Ninth Biennial Cardiovascular Seminar, sponsored by the Heart Association of Greater Miami and the cardiology section of the University of Miami School of Medicine, will be held May 5-7 at the Carillon Hotel, Miami Beach. Major topic of the seminar is entitled "Newer Methods in Ischemic Heart Disease." Further details may be obtained by writing Morton M. Halpern, M.D., seminar co-chairman, c/o Heart Association of Greater Miami, Inc., 5080 Biscayne Boulevard, Miami 33137.

The William Osler Medal of the American Association for the History of Medicine is awarded for the best unpublished essay on a medico-historical subject written by a student in one of the medical schools of the United States or Canada. All students who are candidates for the M.D. degree, or who graduated during 1965, are eligible. Essays with maximum length of 10,000 words should demonstrate either original research or an unusual appreciation and understanding of a medico-historical problem. The prize-winning essay will be submitted to the association's editorial committee for possible publication in the Bulletin of the History of Medicine. Essays must be submitted by March 23 to the chairman of the Osler Medal committee, William K. Beatty, Librarian and Professor of Medical Bibliography, Northwestern University Medical School, 303 East Chicago Avenue, Chicago, Illinois 60611.

A new 35 minute, 16 mm. sound film entitled "The Long-Term Use of Anticoagulants" is now available, according to the Wisconsin Alumni Research Foundation. It was filmed at a recent symposium in New York City featuring a panel of physicians from various parts of the nation who have had considerable experience with anticlotting agents. Arranged by Excerpta Medica Foundation, the symposium was supported by a grant from the Wisconsin foundation. The film is available for loan from Education Division, Wisconsin Alumni Research Foundation, P. O. Box 2037, Madison, Wisconsin 53701.

Members In The News

Dr. Frank C. Coleman of Tampa recently was named pathologist of the year in being selected by the College of American Pathologists as recipient of the Scientific Products Foundation Award for outstanding service to pathology and medicine. A past president of the College, Dr. Coleman currently is chairman of the American Medical Political Action Committee and vice president of the American Association of Blood Banks.

Dr. James N. Patterson of Tampa recently was elected vice president of the American Board of Pathology.

Dr. Hawley H. Seiler of Tampa recently was elected a member of the editorial board of the Annals of Thoracic Surgery. He also was reelected secretary-treasurer of the Southern Thoracic Surgical Association.

Dr. Donald W. Smith of Miami recently was elected to the office of president-elect of the Florida Division, American Cancer Society. Dr. Sam Wesley Denham of Jacksonville assumed the presidency of that organization in October, 1965, having served for the previous year as president-elect.

THE DUVALL HOME
for RETARDED CHILDREN

A home offering the finest custodial care with a happy home-like environment. We specialize in the care of infants, bed-ridden children and Mongoloids.

For further information write to

MRS. A. H. DUVALL GLENWOOD, FLORIDA

(Continued from page 43)

coordinating agency, should be done. In this way, the seminars and conferences will be spread out over the year without overlapping and thereby guaranteeing a better turnout and attendance for all of the courses offered. We would like the thoughts of the physicians throughout the state concerning this possibility.

We would also like to request that the physicians of the state let you know by letter or wire how they feel about booking regional seminars, i.e., like the Crossroad Conferences that we had several years ago on cancer. These seminars would be held at every town and hamlet at varying times throughout the year by a team of specialists in each of the major fields depending on what the area physicians feel they are deficient in or would like to have. In this way there will be a great deal of brushing up for both the practitioner in the field and the specialty man in the big centers, in which both will benefit by the experiences of the other. Sometimes a lone practitioner in some rural area may have a pearl of wisdom or some off-hand research that might lead to very important discoveries for the benefit of the whole.

We would also like to point out, at the present time, experimentation is being done on the possibility of two way telephone communication which is financially more feasible than radio or television at this time in projecting live grand round and other conferences from the medical centers and larger institutions throughout the state to the outlying districts. A pilot program, at the present time, has been projected several times from the University of Florida, as a test, to Flagler Hospital in St. Augustine. By this method, on a specified day, for one hour the practitioners in the smaller hospitals can hear a CPC or some specific subject discussed live from the institution, at the same time with an open wire where questions can be asked and interest and education projected in a very personal manner. We are exploring this possibility further and hope to project programs in the near future to the entire state and to any interested hospital or county medical societies.

It is our belief, at this time, that every physician in this state has available to him or will have available to him some method of continuing education and, if he does not take advantage of the opportunities at his fingertips, he has no one to blame but himself. We will welcome any suggestions or criticisms of the programs we have outlined.

With best personal regards, I remain,

Sincerely yours,
J. J. DeVito, M.D.
Chairman, Committee on
Postgraduate Education
Florida Medical Association

SPECIALTY NEWS

Neurosurgery

The mid-year scientific meeting of the Florida Neurosurgical Society was held November 6-7, 1965, at the Robert Meyer Hotel in Jacksonville, with 21 Florida neurosurgeons and five neurosurgical residents in attendance.

The guest speaker for November 6 was Dr. Lee Farr, professor of nuclear and environmental medicine and chief of the Section of Nuclear Medicine, Department of Medicine, Graduate School of the Biomedical Sciences, University of Texas, M. D. Anderson Hospital and Tumor Institute, Houston. His appearance was made possible by a grant from the Florida Division, American Cancer Society, which defrayed part of the cost of his expenses.

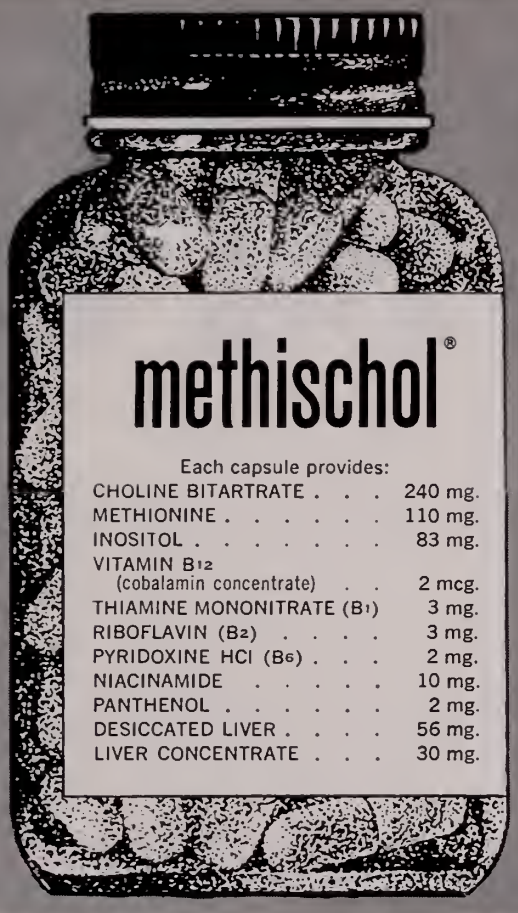
The principal speaker November 7 was Dr. Herbert A. Burke Jr., a Jacksonville endocrinologist, who addressed the Society by invitation. His subject was entitled "Hypothalamic Pituitary Relationships." The remainder of the scientific program consisted of papers by members.

The next meeting of the Society will be held in conjunction with the Florida Medical Association annual meeting May 14 at the Diplomat Hotel, Hollywood Beach.

Edward J. Sullivan, M.D.,
Jacksonville

NEW IMPROVED FORMULA

now with added B complex vitamins



METHISCHOL

original lipotropic formula

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SIGNEM

A 'MAXIMUM SECURITY' ANTIBIOTIC*

* THE BROAD RANGE DEPENDABILITY OF TETRACYCLINE
long established as the broad-spectrum agent of first choice in a wide variety of infections

* WITH THE ADDED SECURITY OF MEDIUM-SPECTRUM REINFORCEMENT
triacetyloleandomycin is highly active against the common 'coccal' pathogens, including certain strains of staphylococci resistant to penicillin and tetracycline

* ESPECIALLY VALUABLE IN U.R.I.
provides decisive therapy in acute respiratory infections and other conditions in which staphylococci, streptococci or mixed flora are frequently encountered

* NOW AVAILABLE IN NEW STRENGTH FOR NEW CONVENIENCE AND ECONOMY
Signemycin 375—high-potency capsules for simpler administration, greater patient economy

YCIN® 375

(tetracycline 250 mg. triacetyloleandomycin 125 mg.)

ndications: Indicated in the therapy of acute severe infections caused by susceptible organisms and primarily by bacteria more sensitive to the combination than to either component alone. In any infection in which the patient can be expected to respond to a single antibiotic, the combination is not recommended. Signemycin should not be used where a bacteriologically more effective or less toxic agent is available. *Triacetyloleandomycin, a constituent of Signemycin, has been associated with deleterious changes in liver function.* See precautions and adverse reactions.

Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug. Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

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Whaddaya mean would I fix my own plumbing?
Of course I'd fix my own plumbing. I'm a plumber.

Whether the sinusitis patient comes to you at the first sign of trouble or as a last resort, you can give him the relief he's looking for with Novahistine Singlet.

A single tablet provides prompt analgesic effect, for relief of sinusitis pain. Then Novahistine Singlet also attacks the underlying cause of the headache—helping to open blocked respiratory passages and restore normal sinus drainage. The continuous decongestant effect produced by one Novahistine Singlet every 8 hours reduces the chances of acute sinusitis progressing to chronic stages.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Tell ambulatory patients that Novahistine may occasionally cause drowsiness.

Each tablet contains phenylephrine hydrochloride, 40 mg., chlorpheniramine maleate, 8 mg., and acetaminophen, 500 mg.





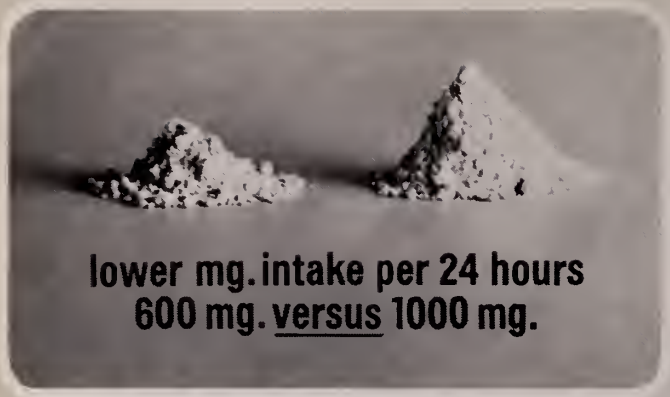
Saxon

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis

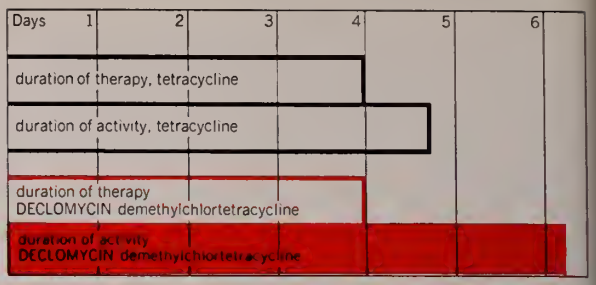
Dow

NOVAHISTINE® SINGLET™

For relief of sinusitis pain and congestion.

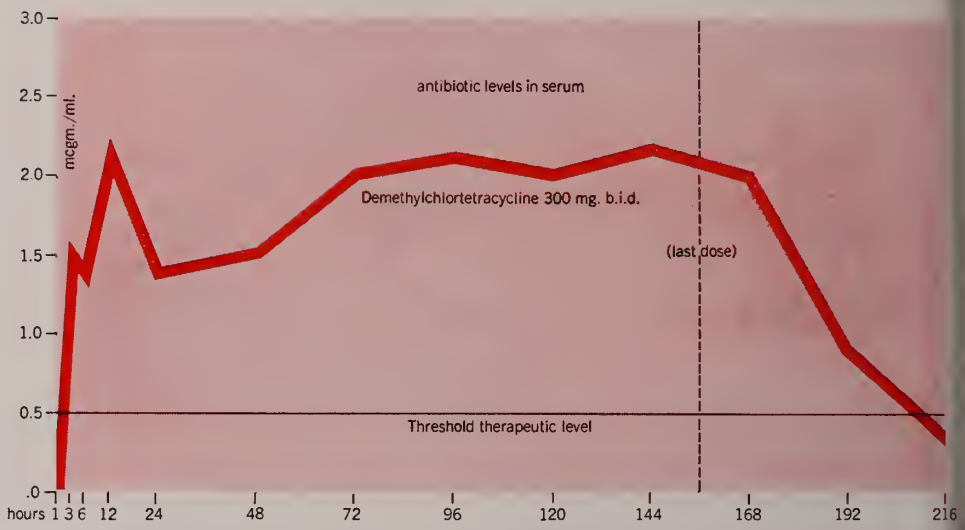


lower mg. intake per 24 hours
600 mg. versus 1000 mg.

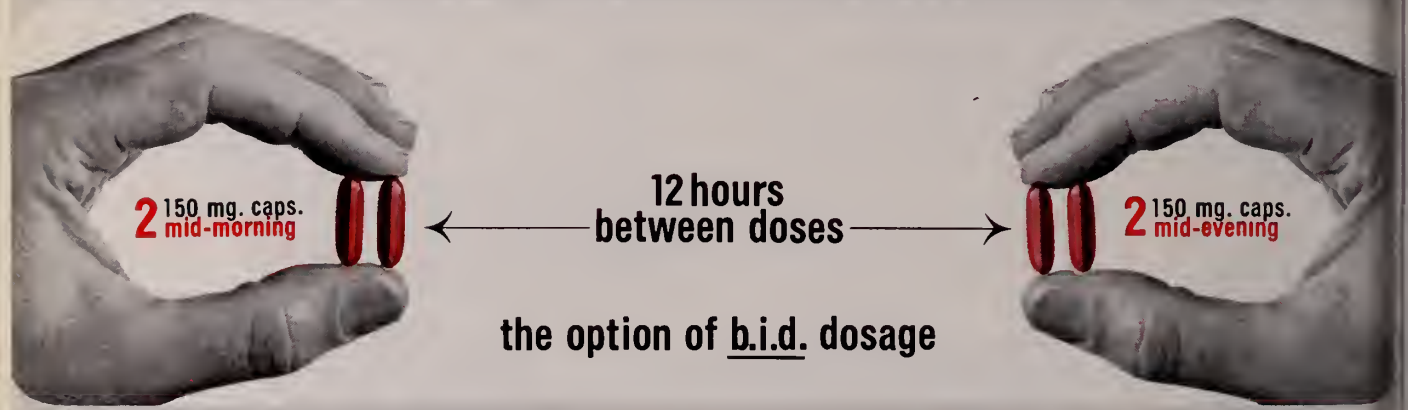


1-2 days "extra" activity

higher activity levels than other tetracyclines—with less peak-and-valley fluctuation



From Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.; Amer. J. Med. Sci. 243:296 (Mar.) 1962



the option of b.i.d. dosage

the "extra" benefits raise the level of antibiotic control

DECLOMYCIN
DEMETHYLCHLORTETRACYCLINE
150 mg. CAPSULES

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Side effects typical of tetracyclines include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation) and increased intracranial pressure (in young infants). Also, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. Because of reactions to artificial or natural sunlight (even from short exposure and at low dosage) patient should be warned to avoid direct exposure. Stop drug immediately at the first sign of adverse reaction. It should not be taken with high calcium drugs or food; and should not be taken less than one hour before, or two hours after meals.

Capsules, 150 mg. and 75 mg. of demethylchlortetracycline HCl
Average Adult Daily Dosage: 150 mg. q.i.d. or 300 mg. b.i.d.

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Announcing
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pargyline hydrochloride 25 mg. and methyclothiazide 5 mg.

for control of moderate to severe hypertension

Unique combination produces greater antihypertensive effect with lower doses

Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.



Each Eutron tablet contains two proven antihypertensives in the ratio shown to be most effective in most patients.

TM—TRADEMARK

New **EUTRON** extends your range of treatment in moderate to severe hypertension



A single product you can use even in the presence of congestive heart failure or edema

Eight out of 10 patients respond

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

512214

1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.



BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week — maximum reduction in seven to ten days.



Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for **EUTRON**

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

ABBOTT

512214



following infection

RESSCAPS B and C vitamins in therapeutic amounts...help the body bilize defenses during convalescence...aid response to primary therapy. e patient with a severe infection, and many others undergoing physio- ic stress, may benefit from STRESSCAPS.

STRESSCAPS®

Stress Formula Vitamins Lederle

Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

DERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY Pearl River, N.Y. Lederle



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

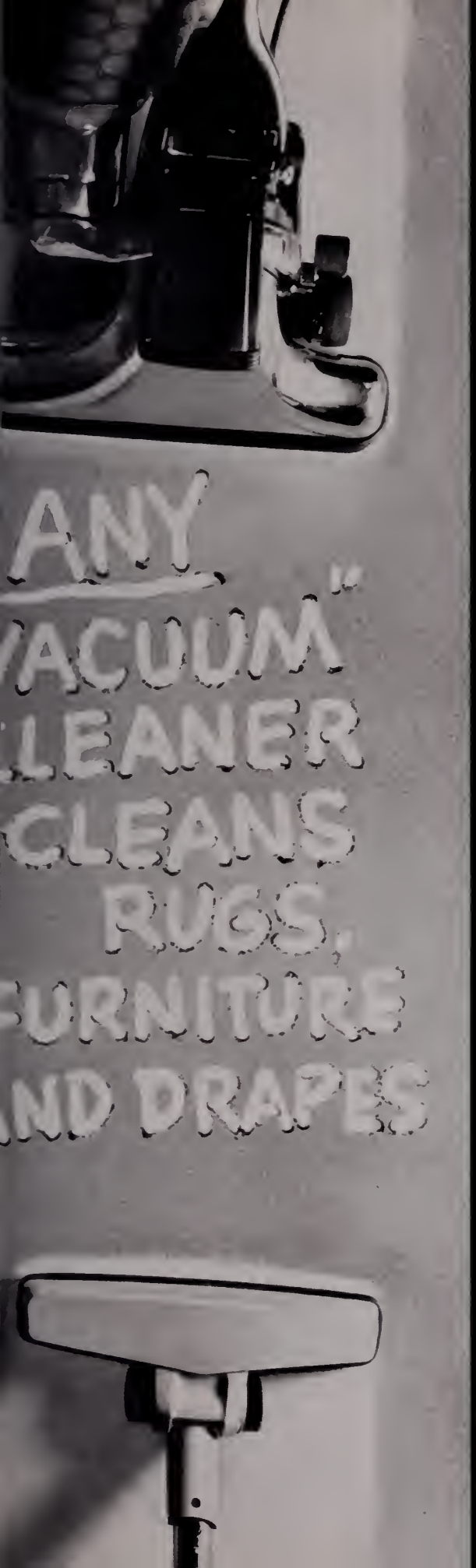
Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

WALLACE LABORATORIES
Cranbury, N.J.

CM-5761

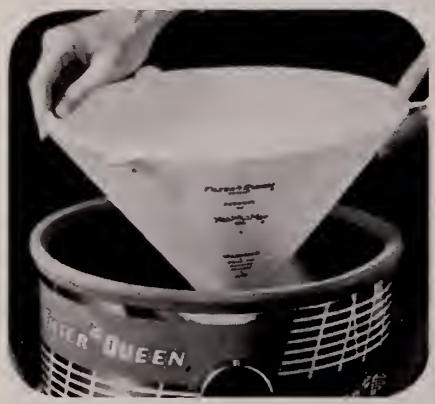


Only
Filter Queen
cleans the
air, too!



Proof? See inside—

DRAMATIC TEST PROVES FILTER QUEEN TRAP



1 Place a fresh Sanitary Filter Cone in the FILTER QUEEN container. (It takes only a moment to open the machine and replace the old Filter Cone.)



2 Now unfold a clean white handkerchief and drop it into the Sanitary Filter Cone. (Even the daintiest, sheerest handkerchief may be used with perfect safety.) Then replace the turret top on the container.



3 Now turn the machine over to any one witnessing the demonstration, and have her start the machine and apply the nozzle to a place where there is obvious dirt and dust. Keep the machine operating for a full minute.

See the proof with the
FILTER QUEEN
"clean handkerchief" test

4 Remove the top of the container, and lift out the handkerchief. You'll find it spotless as it was when it went in! (Where did the dirt go? Look in the bottom of the container.)



DUST AS NO "VACUUM CLEANER" CAN!

Revolutionary...and in a class by itself!

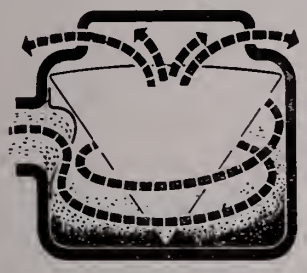
FILTER QUEEN

has the scientific cleaning features that hospitals need most

All "vacuum" cleaners were much the same until the FILTER QUEEN SANITATION SYSTEM was designed. FILTER QUEEN'S patented Sanitary Filter Cone eliminates the need for messy bags, traps practically all airborne contaminants passing into the machine (Harvard Medical School Report in Journal of the American Medical Association, November 25, 1958).*

Experienced hospital housekeepers know this well. That is why FILTER QUEENS have replaced every type of vacuum cleaner in hundreds of hospitals throughout the world.

FILTER QUEEN has no porous bag that permits dust and dirt to reenter the room. FILTER QUEEN operates on an entirely different principle, "Cyclonic Cleaning Action." Here's how it works: Inrushing air, laden with dirt and dust, is deflected by a patented inlet guide as it enters the



container; then is whirled by centrifugal force away from the cone. Dust and dirt are dropped to the bottom of the container. (See illustration.) Air, being lighter, is funnelled to the center of the "cyclone," filters through the Sanitary Filter Cone and returns to the room dust-free.

Why not ask your local FILTER QUEEN Distributor to make the dramatic handkerchief test (pictured at left) in your hospital? There is no better way to prove the improvement in cleaning ability between a FILTER QUEEN SANITATION SYSTEM and any type of vacuum cleaner. (You'll find your distributor listed in the Yellow Pages; or write Health-Mor, Inc. direct).

**We will be glad to send you a reprint of this report on request.*

What hospital administrators say about FILTER QUEEN

"I heartily recommend to any hospital administrator who is presently unhappy with the type of cleaning machine in use, that he try FILTER QUEEN for only two days and the machine will sell itself."

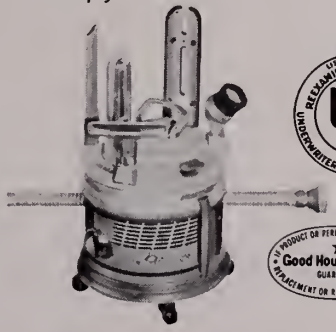
"The FILTER QUEEN is great—a very important factor in patient areas, and is constructed so as to prevent air turbulence of dust at floor level. Filtering of the air, while in general operation, is also a very important and desirable factor."

"One of the most pleasing features of the machine is its quietness. We can even clean in the rooms while occupied by the patients, and many have commented on how pleasant it is not to be disturbed by noisy, old-fashioned vacuum cleaners anymore."

"The air exhaust at the top of the unit is a wonderful feature, and the Sanitary Filter Cone is certainly our answer for working in closely confined patient areas."

"We thought we had a clean hospital and a fairly good method of achieving acceptable sanitation, but this little machine made us revise our thinking and our methods."

"A quiet motor which possesses excellent cleaning power and the convenience of having to clean out the cleaning compartment only once a month, has proved very advantageous. One of the most important points . . . is that there is no bag to empty."



FILTER QUEEN

In Canada: Filter Queen Corp., Ltd., 252 Victoria Street, Toronto, Ont. • In Mexico: Industrias Filter Queen, S.A., Av. Jardin #330, Col. del Gas, Mexico 15, D.F.

A Product of HEALTH-MOR, INCORPORATED, 203 North Wabash Avenue, Chicago, Illinois 60601


Treat his
bacterial
upper respiratory
infection with tetracycline, but also consider relief of his
pain, headache, fever, malais

ectively combat bacterial infection and maintain relief of respiratory symptoms

Tetrex®-APC

with Bristamin®

(tetracycline phosphate complex with analgesics and antihistamine)

advantages of Tetrex®
cycline phosphate complex).
ntains the basic tetracycline
is less bound to serum pro-
han is demethylchlortetracy-
. (It puts a higher percentage
ive antibiotic into the blood.)
sic tetracycline is also better
ated than oxy- or demethyl-
tetracycline.[2,3] *Unlike de-*
ylchlortetracycline,[4] no cases
otodynamic skin reaction have
reported with Tetrex (tetra-
ne phosphate complex).

with the benefits of APC and Bristamin (phenyltoloxamine citrate). Traditional APC provides predictable relief of pain, fever and malaise in acute respiratory infections, while the phenyltoloxamine citrate—notable for its effective histamine-blocking action with minimal drowsiness—adds relief of watering eyes, rhinorrhea, congestion and "tight" chest symptoms.

References: 1. Roberts, C.E., Jr.; Perry, D.M.; Kuharic, H.A., and Kirby, W.M.M.: Arch. Int. Med. *107*:204 (Feb.) 1961. 2. Dowling, H.F.; Lepper, M.H., and Jackson, G.G.: Clin. Pharmacol. & Therap. *3*:564 (Sept.-Oct.) 1962. 3. Editorial: Antibiotics & Chemother. *11*:427 (July) 1961. 4. Baer, R.L., and Harber, L.C.: JAMA *192*:989 (June 14) 1965.

BRISTOL THERAPEUTIC SUMMARY. For complete information, consult Official Package Circular. *Indications:* Upper respiratory infections due to sensitive bacteria where concomitant symptomatic relief of fever, malaise and congestion is desired. *Contraindication:* A past history of hypersensitivity to one or more components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if discomfort occurs. No cases of photosensitivity have been reported with Tetrex (tetracycline phosphate complex). With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Antihistamines may cause drowsiness and patients should not perform tasks requiring mental alertness while taking this agent. Bacterial or mycotic superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for three months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. *Usual Adult Dose:* Two capsules *q.i.d.* Continue therapy for at least 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

STOL

OL LABORATORIES / Division of Bristol-Myers Co., Syracuse, New York

The tell-tale lesion on the back of her neck



ARISTOCORT Topicals are particularly effective in controlling the inflammatory symptoms of many dermatoses including neurodermatitis, atopic dermatitis, eczematous dermatitis, seborrheic dermatitis and certain cases of psoriasis. The 0.1% Cream or Ointment is usually effective in abating symptoms of skin conditions responsive to topical triamcinolone, but the 0.5% Cream may be preferable in more resistant cases. *Dosage:* Apply small quantity to area 3 or 4 times daily. Side effects are rare. *Contraindications:* tuberculosis of the skin, herpes simplex, chickenpox, and vaccinia. Use with care on infected areas. Do not use in the eyes. Supplied in 5 and 15 Gm. tubes and ½ lb. jars. Also available in foam form and with Neomycin.

Aristocort® TOPICAL CREAM 0.1% AND OINTMENT 0.1%

Triamcinolone Acetonide

LEDERLE LABORATORIES • A Division of American Cyanamid Company, Pearl River, New York

Lederle

630-6



more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201



On Stelazine® brand of trifluoperazine she's calm and alert

When a tranquilizer is needed, 'Stelazine' can regulate the level of anxiety so that the patient is unlikely to overreact to stress but is not tranquilized into psychic inertia. Patients on 'Stelazine' often experience a sense of mental alertness and, because they feel so much better, are more interested in their normal activities.

Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

Before prescribing, see SK&F product Prescribing Information.

Photograph professionally posed.

SK&F

Smith Kline & French Laboratories

when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

Geriliquid®



IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.

Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

Supplied: Bottles of 8 oz. and 16 oz.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

Need a pocket watch?



See your jeweler!

Need another car?



Visit your auto dealer!

Need optical services?

GUILD ℞ OPTICIANS ®

Call on an expert —

YOUR GUILD OPTICIAN!

Just as the jeweler is trained in his field, and the auto dealer is knowledgeable in his business, the Guild Optician is an expert in *his.*

We say "Call on an expert . . ." because your local Guild Optician *is* an expert in mechanical optics. You know he is equipped to handle your most critical cases, both in experience and in training. You know also, because he is a Guild Member, that his standards are high, and that you can depend on him to accurately translate your patient's prescription and to render such after service as your patient might need, for the life of that prescription.

Your local Guild Optician also is an expert at working with your patient in an understanding manner when it comes to the styling and fit of your patient's frame. His stocks reflect not only the most modern fashions, but also the conservative styles that have lasted over the years.

There are, of course, many other areas in which your Guild Optician may be highly skilled: sub-normal vision cases, aphakic cases, contact lenses.

When *you* need optical services, think *first* of your Guild Optician! *Guild of Prescription Opticians of Florida.*

USING GUILD SKILLS AND EXPERIENCE TO SERVE YOUR PATIENTS

the price of "success"

190/102

Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

THERAPY
YOU CAN STAY
WITH

METATENSIN®

EACH SCORED TABLET CONTAINS:
Metahydrin® (trichlormethiazide) 2 mg. or 4 mg. Reserpine 0.1 mg.

In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

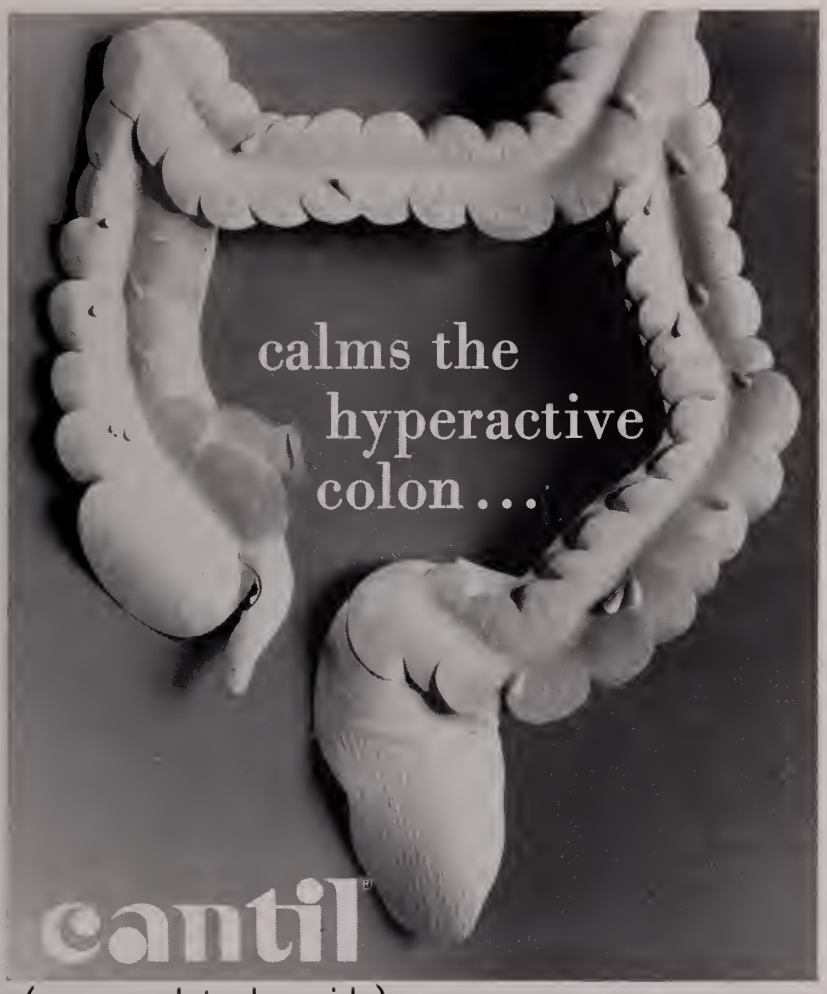
Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.







(mepenzolate bromide)

helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201



The Pain Is Gone

Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

'Empirin'® Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

Keeps the Promise of Pain Relief

BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.



approximating the diuretic efficacy of meralluride

METAHYDRIN®
(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.



introduce your patient to

aquaTAG®

(BENZTHIAZIDE)

NEW FROM TUTAG for fast, emphatic diuretic action with a balanced excretion of sodium and chloride and a lower potassium loss under normal dosage and diet regimen.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or disfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

Before prescribing or administering, read the package insert or file card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.

S.J. TUTAG & COMPANY
Detroit, Michigan 48234

a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

often relieves mental pain in 2-5 days

NORPRAMIN®
(desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

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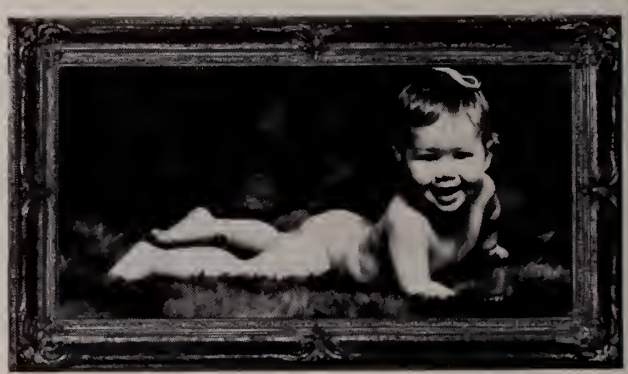


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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957

2—Asher, L.M.: Am. J. Digestive Diseases *4*:272 (Apr.) 1959

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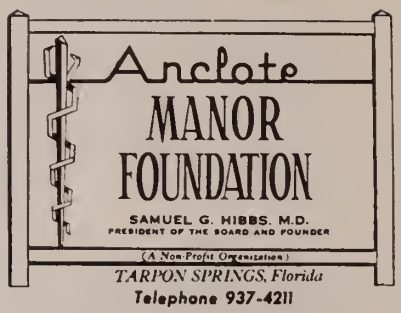
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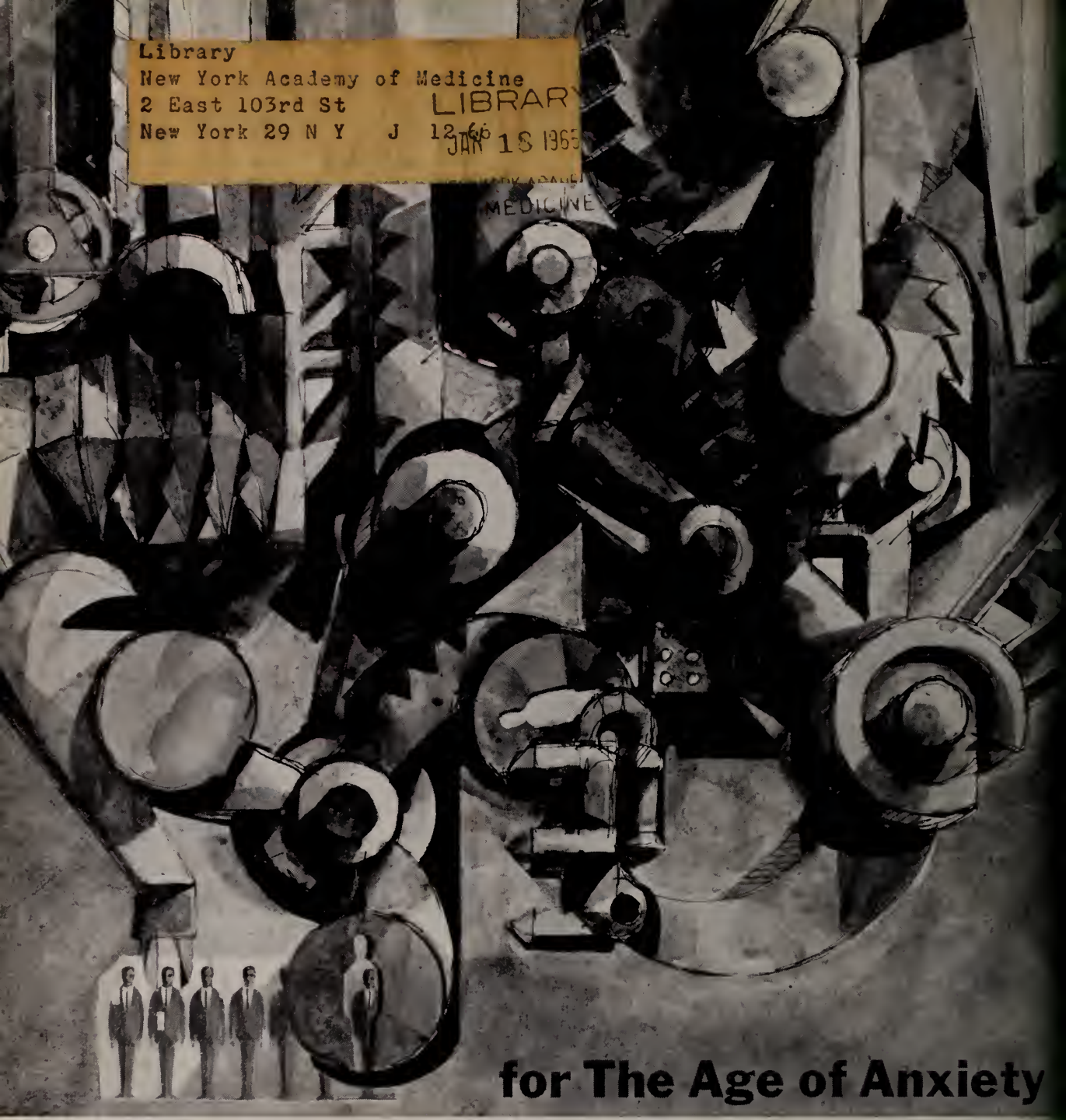
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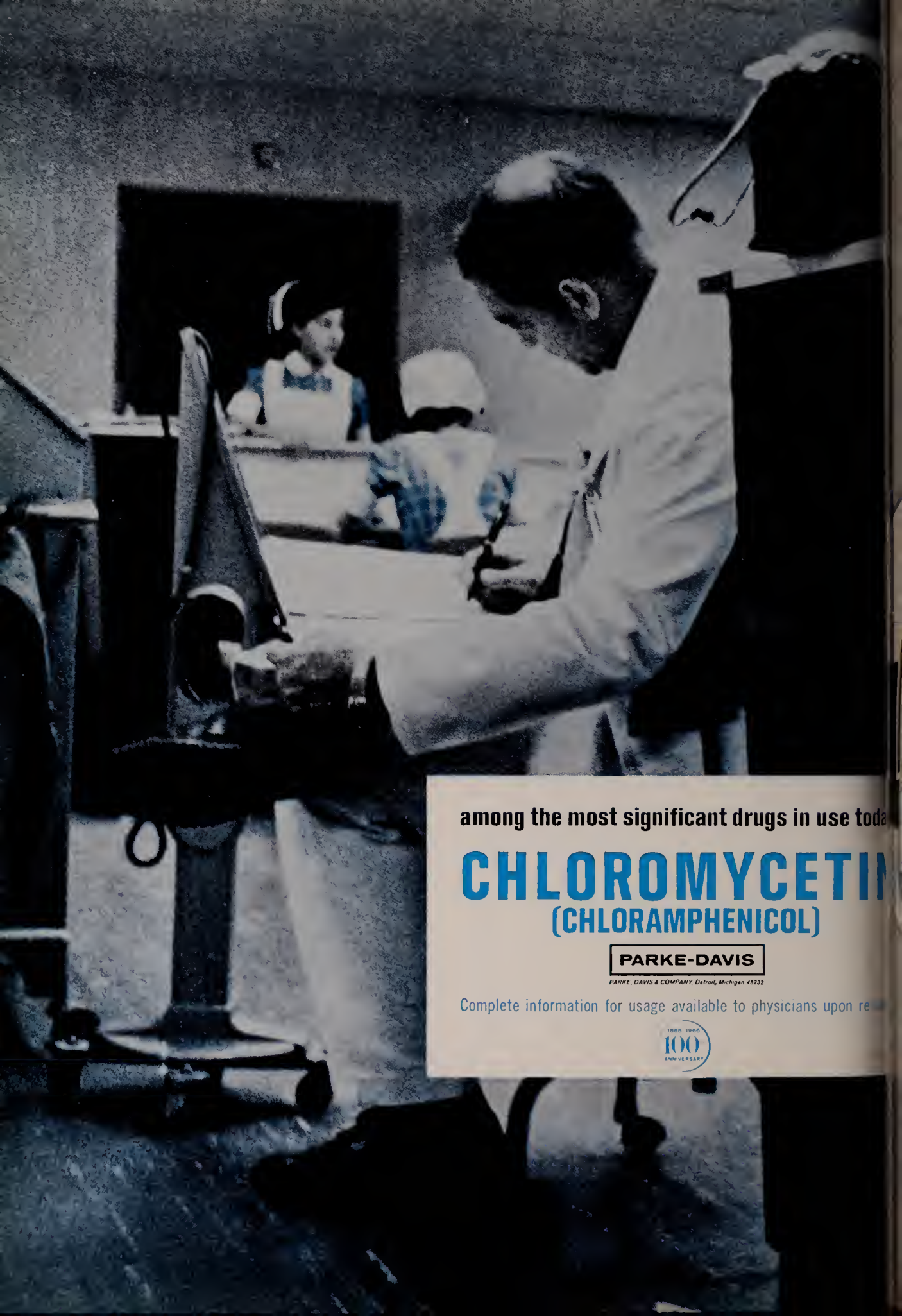
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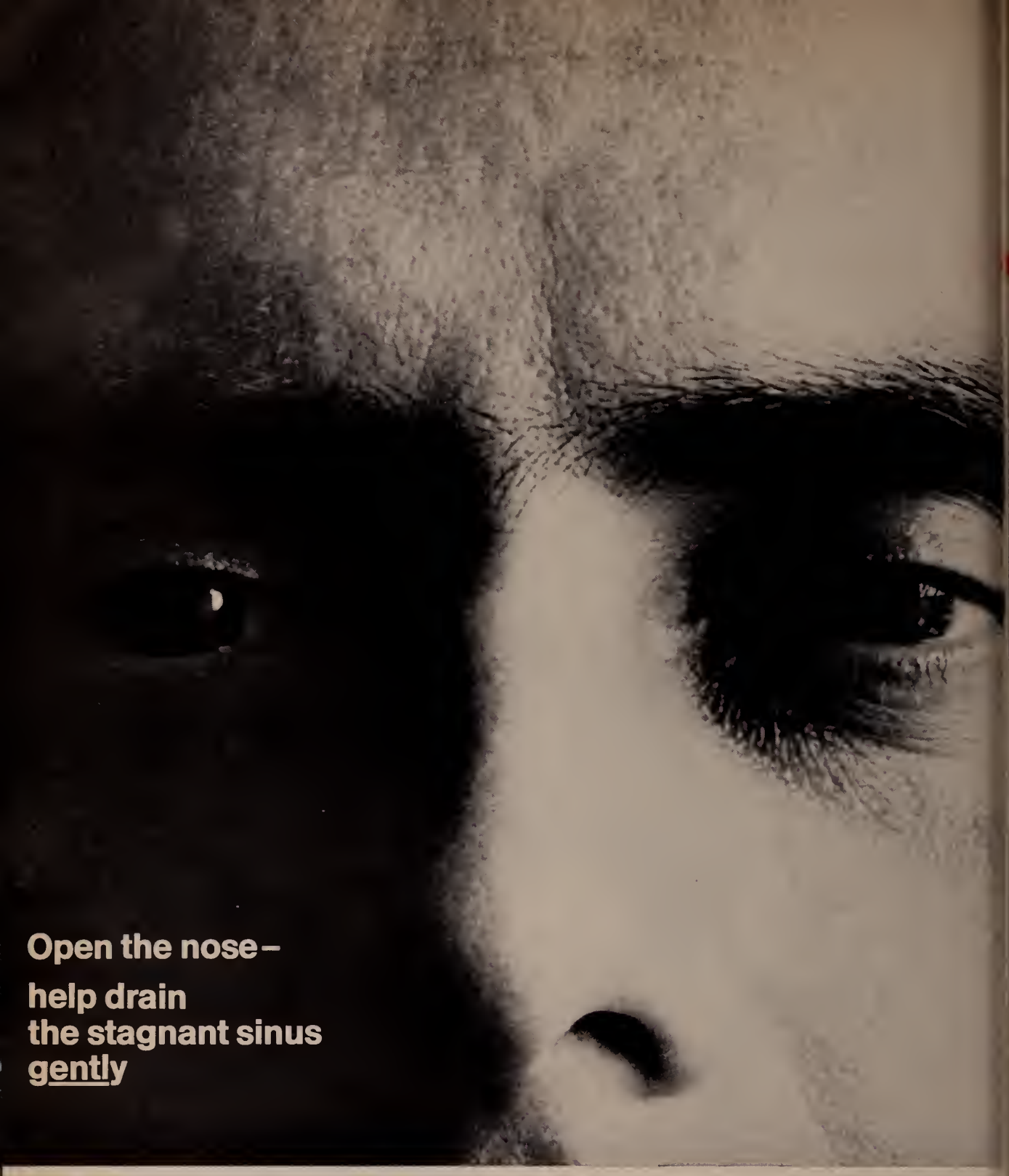
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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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The JOURNAL
of the Florida Medical Association

Volume 53, Number 2, February 1966

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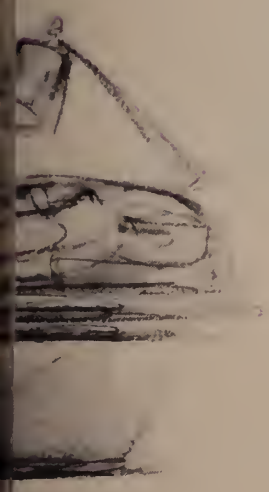
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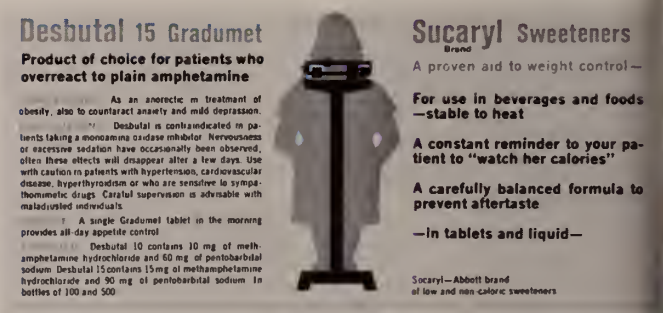
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90 mg. Pentobarbital Sodium

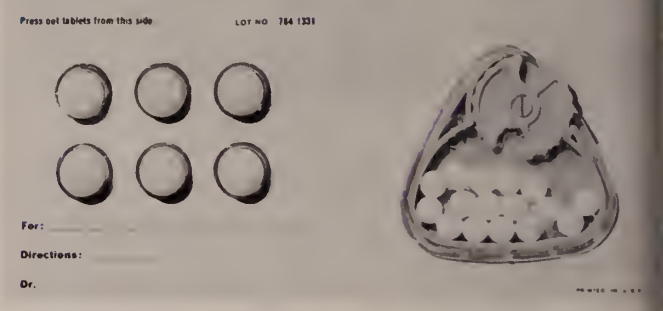
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References: 1. Roberts, C.E., Jr.; Perry, D.M.; Kuharic, H.A., and Kirby, W.M.M.: Arch. Int. Med. *107*:204 (Feb.) 1961. 2. Dowling, H.F.; Lepper, M.H., and Jackson, G.G.: Clin. Pharmacol. & Therap. *3*:564 (Sept.-Oct.) 1962. 3. Editorial: Antibiotics & Chemother. *11*:427 (July) 1961. 4. Baer, R.L., and Harber, L.C.: JAMA *192*:989 (June 14) 1965.

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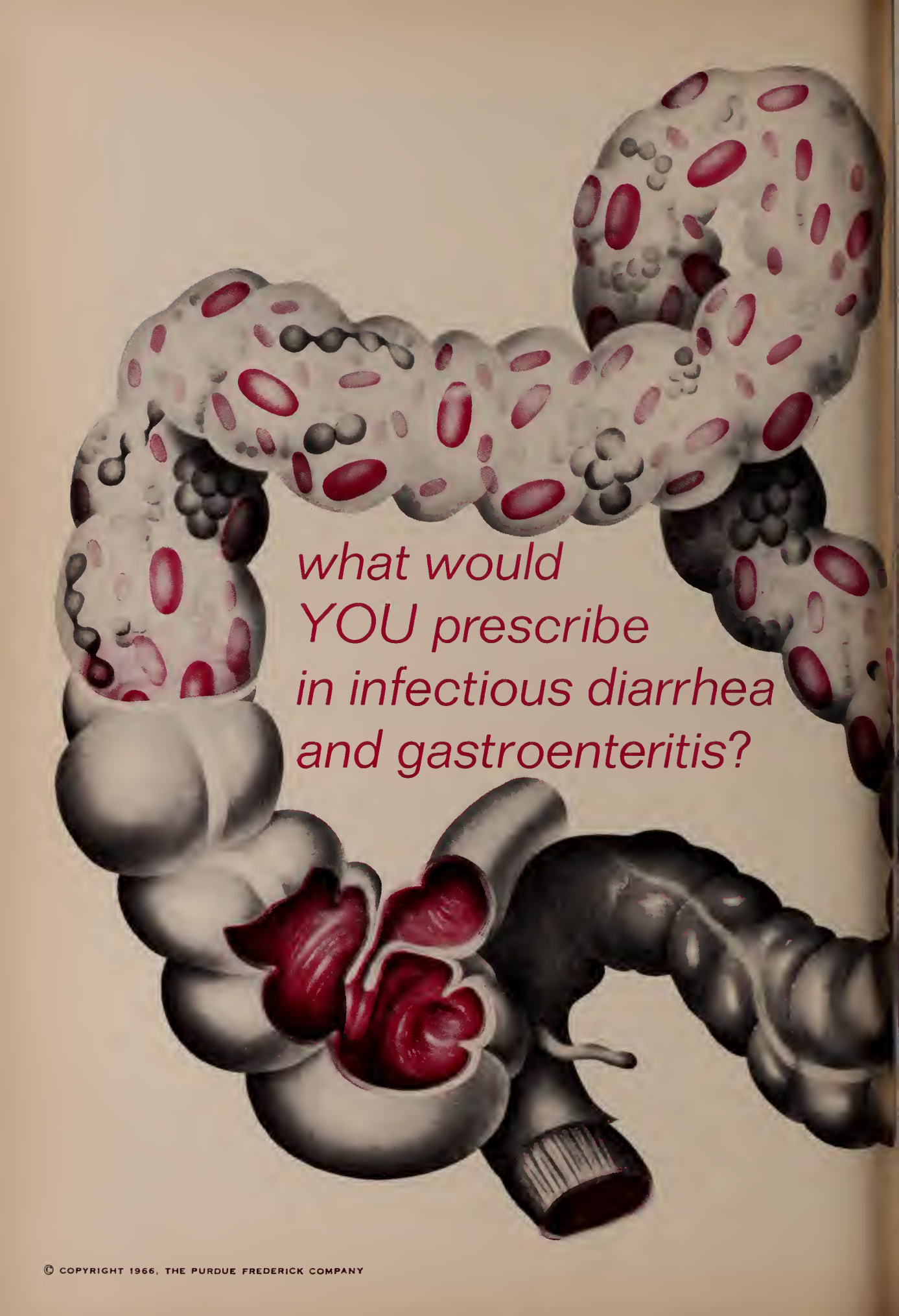
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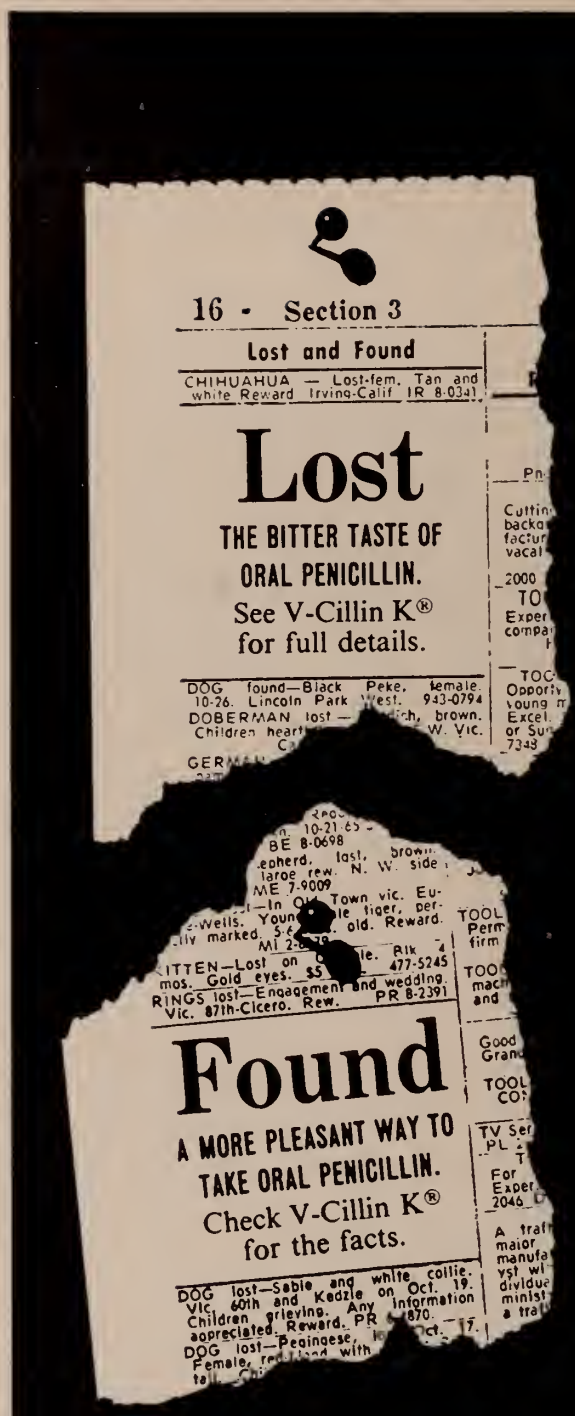
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The JOURNAL
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The Rationale of Extended Resection for Complicated Cancer of the Large Bowel

Hiram C. Polk Jr., M.D.
MIAMI

Survival of persons ill of cancer of the colon and rectum has significantly improved over the last four decades, contrary to that of patients with many other common neoplasms.[1] Such improvement, manifest by a doubling of five year survivors, is almost entirely due to increased operability and resectability and to reduced surgical mortality.[2] While surgeons may take justifiable pride in such accomplishments, they must be alert to opportunities to increase survival further among patients with colorectal carcinoma. Several recent studies indicate that a more aggressive attack upon the large, locally advanced neoplasm of the large bowel is likely to salvage a significant number of patients heretofore deemed incurable. It is the purpose of this paper to review these studies and to present four patients seen within the last year who illustrate such concepts.

The Biology of Colonic Cancer

Like any other malignant neoplasm, cancer of the colon and rectum represents a broad spectrum of appearance and behavior. Taken as a whole, however, colonic cancers possess distinctive characteristics. It has been clearly shown that the frequency of regional lymph node metastases is unrelated to the size of the primary tumor.[3] The large, locally advanced carcinoma is often not associated with regional or distant metastatic deposits whereas the small lesion will upon occasion be the source of regional and/or systemic metastases.[4,5]

Similarly, careful autopsy studies of patients dying of carcinoma of the colon and rectum consistently show that the tumor is locally advanced without hepatic or systemic metastases in 40 to 67%.[6,7] Thus, an appreciable portion of patients actually dying of colonic cancer could be salvaged by proper extension of standard resections. These data apply even more directly to the tumor which has been excised previously and is recurrent. Rather than accepting local recurrence as proof of incurability, such patients should have the benefit of reoperation and reresection if possible. Certainly, a number of patients with local recurrence in and about the suture line, after anterior resection, have remained well following reoperation and abdominoperineal resection or pelvic exenteration.[8,9]

Adenocarcinoma arising in the colon and rectum is relatively slow-growing with doubling times on the order of 600 days.[10] Furthermore, multiple primary carcinomas exist in three to five per cent of those patients initially seen for surgical therapy.[11] This figure excludes such cancer-prone persons as those with chronic ulcerative colitis or true multiple polyposis and is, therefore, all the more meaningful. Finally, colonic carcinoma invading adjacent organs rarely, if ever, metastasizes along the lymphatic drainage pathways of the invaded organ, for example, small intestinal mesentery.

A Change of Concepts

Recently, many heretofore unchallenged concepts regarding operative treatment of large bowel

From the Department of Surgery, University of Miami School of Medicine and Jackson Memorial Hospital, Miami, Fla. 33136.

carcinoma have been critically studied and found wanting in rationale or result, or both.

A study of 856 consecutive operations for carcinoma of the colon and rectum in one university hospital has shown that operative risk is not adversely affected by: (1) the size of the primary neoplasm; (2) extensive resections of lymph node bearing tissue; (3) the presence of regional nodal metastases; (4) the length of resected intestine; and (5) the resection of additional organs grossly or microscopically involved by the neoplasms. Finally, death after operation was significantly (p=.009) more frequent when the surgeon performed a locally noncurative procedure than when all the primary tumor, including adjacent organs, was excised.[12]

A particular case in point is the primary or recurrent carcinoma of the rectum or sigmoid which invades the urinary bladder. Pelvic exenteration with ileal segment urinary diversion has been applied to those cases in which distant metastases are absent with acceptable risk and survival. Indeed, the earliest report of a large experience with pelvic exenteration for such lesions recorded that 12 of 25 patients operated upon were alive and free of disease 13 to 94 months after operation.[13] Data from the same institution indicate that the operative risk of pelvic exenteration for carcinoma of the large bowel has been reduced from 16% initially to 7% presently.[14]

Another fertile field for a worth while extension of present therapy is that of perforative colonic carcinoma. There is increasing awareness that inflammatory reaction, be it gross or microscopic, about a malignant neoplasm may favorably alter the prognosis for the tumor host. This has been demonstrated for gastric, mammary and colonic cancers in man.[15,17] It then is not surprising that a favorable prognosis following resection of perforated colonic cancers has been confirmed in two widely separated institutions with vastly different populations.[18,19] Following proximal colostomy and adequate drainage of the perforation, staged resection of the cancer-bearing portion of the bowel may achieve survival rates not greatly different from those obtained in any group of colorectal carcinomas. Here is another seemingly incurable cancer which has been shown logically and practically to be highly curable.

A further incentive to extend safely standard resections of the colon is studies demonstrating the most frequent present causes of death after operations upon the large bowel to be cardiopulmonary complications. Only about 1 per cent of patients undergoing colon resection will die of complications directly related to the surgical procedure.[2] With continued improvement in supportive care, it seems likely that locally advanced lesions can be safely resected more often than has been the practice in the past.

Report of Cases

Case 1. — A 60 year old woman was admitted to the hospital with vague abdominal discomfort. Barium enema demonstrated an annular, constricting carcinoma of the transverse colon, but she refused operation. Fourteen months later the patient was readmitted with melena, anemia and congestive heart failure. She responded to digitalis preparations and transfusion of packed red cells. Barium enema demonstrated enlargement of the neoplasm in the transverse colon. At celiotomy, the bulky colonic tumor was grossly invading the small bowel at the ligament of Treitz. En bloc resection of the proximal jejunum with subtotal colectomy was followed by end to end duodenojejunostomy and cecosigmoidostomy. She convalesced uneventfully. Pathologic examination showed colonic adenocarcinoma invading the small bowel with clot at the site of two neoplastic ulcerations in the jejunum. Each of 18 mesenteric nodes was free of cancer. At reoperation, eight months later, for obstruction of the small intestine due to adhesions, there was no evidence of recurrent or persistent carcinoma.

Case 2. — An 83 year old man, admitted to the hospital for atrial fibrillation and congestive heart failure, was found to have a large, hard, epigastric mass. His cardiac status improved and barium enema showed a huge tumor of the transverse colon. At celiotomy the tumor was found to invade the falciform ligament and left rectus sheath as well as the mid-jejunum. Liver metastases were absent and the tumor was otherwise movable. Resection included the falciform ligament and left rectus sheath and muscle, a segment of jejunum with mesentery, and subtotal excision of the colon; ileosigmoidostomy, jejunojejunostomy, and fascial flap from the right anterior rectus sheath comprised the repair. Following vigorous coughing on the fifth postoperative day, the fascial repair dehisced, producing an epigastric incisional hernia. He was discharged with an abdominal support on the twelfth postoperative day. Pathologic examination demonstrated a mucinous adenocarcinoma with extension to jejunum and abdominal wall. None of 12 mesenteric lymph nodes contained cancer.

Case 3. — A 63 year old man underwent standard right hemicolectomy with en bloc cholecystectomy for adenocarcinoma of the hepatic flexure invading the muscularis of the gallbladder. All 45 lymph nodes in the specimen were free of cancer. Ten years later symptoms of left colonic obstruction developed. Reoperation disclosed new primary neoplasms of the left transverse and descending colon. Subtotal colectomy and ileoproctostomy were followed by an uneventful convalescence. The patient had no evidence of carcinoma when examined three years later and died suddenly one year subsequently.

Case 4. — A 72 year old man was subjected to an exploratory operation for an adenocarcinoma of the upper rectum and found to have invasion of the base of the bladder and prostate. Terminal sigmoid colostomy was performed and the patient referred for possible pelvic exenteration. Two weeks later total pelvic exenteration with ileal segment urinary diversion was carried out. His postoperative course was unremarkable except for unexplained hypotension on the tenth postoperative day which

responded to infusion of lactated Ringer's solution. He was dismissed on the seventeenth day after operation. Pathologic examination showed an extensive adenocarcinoma of the rectum invading the bladder and prostate. Twenty-three excised lymph nodes were free of tumor.

Discussion

A review of the biologic behavior of carcinoma of the colon and rectum and the results of surgical treatment provide a firm basis for resecting those neoplasms which are locally invasive but which do not have clinical evidence of hepatic or systemic dissemination. The absence of nodal metastases in the four illustrative cases further enhances the likelihood of prolonged control of disease with probable cure in each. Upon occasion it has been possible to resect en bloc involved organs such as the stomach, duodenum, small bowel, liver, gallbladder, kidney, ureter, urinary bladder, female pelvic viscera, spleen, portion of the bony pelvis, or abdominal wall and major vessels such as the vena cava, with long term survival free of disease. When the surgeon is mentally prepared for such extended excisions and aided by competent anesthesia personnel, interested assistants, and adequate supportive facilities, operations may be completed which lend the patient a realistic chance for long, happy and productive life.

References are available from the author upon request.

Jackson Memorial Hospital.

Stereotaxic Hypophysectomy in Metastatic Breast Cancer and Progressive Diabetic Retinopathy

Richard E. Strain, M.D.
CORAL GABLES

Stereotaxic hypophysectomy is a relatively new, fairly benign operative procedure which offers the major benefits of hypophysectomy to poor risk patients without subjecting them to a major operative procedure with its attendant dangers and long hospitalization. The procedure may be done under local anesthesia by the transfrontal route with the patient asleep from sedation; so it is applicable to the poorest risk patient in whom general anesthesia may be contraindicated. Its major uses have been for patients with widespread metastatic carcinoma of the breast and for advancing diabetic retinopathy threatening total blindness. Pituitary tumors may similarly be destroyed and patients with acromegaly and Cushing's disease may be relieved by this relatively minor operative procedure.

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Its mode of action, besides actual destruction of pituitary tumors, appears to be the removal of the somatotrophic or "growth" hormone, that fascinating substance apparently secreted by the pituitary, which can exert such a pronounced effect on various tissues including the growth of cancer cells and the endothelial cells and mural cells of the blood vessels of the retina.

For several years I have been interested in the pituitary and the "growth" hormone's effect in various clinical conditions, have visited most of the major medical institutions, and corresponded with most of the workers doing work in this field including those in England, Europe, Boston, and California. Until synchrocyclotrons, such as are in use in Berkeley, Boston, and Sweden, with their generation of neutrons, alpha particles or deutrons and other positive charged "heavy particles" become more widely available, less sophisticated

destruction of the anterior pituitary by coagulation, the cold probe, or radioactive substances such as Yttrium 90, gold 198, or actual excision will be done. The transfrontal route has been used by Hastain-Bennett,[4] Cooper,[13] and others[14] while the trans-sphenoidal route, despite its dangers of infection, spinal fluid rhinorrhea, and requiring a general anesthetic, has been used by others. Most workers agree that complete destruction of the pituitary is neither necessary nor desirable.[7,8] Indeed, Lawrence[7] now makes an effort to use only suppressive doses of heavy particle destruction after earlier experiences with ablative doses.

A brief review of the results of workers in this field is presented and an illustrative case reported.

Metastatic Carcinoma of the Breast and Hypophysectomy

Luft and Olivecrona[1] appear to have been the first to report a concentrated effort to determine the influence of hypophysectomy in patients with neoplastic disease. They reported 75 cases of hypophysectomy in which 55 patients had cancer of the breast.[2] Forty-five per cent had a remission averaging over 17 months.

Ray and Pearson[3] reported on over 500 cases of hypophysectomy in cancer of the breast with a 50% overall objective remission rate on random-selected patients using rigid criteria for remission. In the 60 to 75 year age group 70% had remissions. In those patients who responded to oophorectomy, 91% had a further remission with hypophysectomy. The average remission was approximately two years while some 4 to 5% had four and five year remissions.

Ray used a major craniotomy procedure and reported a 6.7% mortality in 30 days; 1.2% was due to surgery, 3.1% to complications, and 2.3% to advancing cancer. In the stereotaxic procedure morbidity has been five to seven days with practically no mortality. Hastain-Bennett[4] using the transfrontal route had no mortality in 36 cases. Udvarhelyi[5] using the trans-sphenoidal route in 39 cases reported two thirds of the patients were improved with relief of pain often within 24 hours. In three of five patients with rhinorrhea meningitis developed; one died four days postoperatively. Another died because of severe bilateral pleural effusion and cardiac decompensation. Cerebrospinal rhinorrhea and possible infection, in 15 to 17% of cases according to Svien,[6] represent one of the major drawbacks to the transsphenoidal route as compared to the transfrontal route in which such complications do not occur; the other is that a general anesthetic is required.

Lawrence and his co-workers[7] reported on 159 of 161 cases of breast cancer treated, with objective remissions in 35% of these cases. Remissions have lasted in some instances over four years. They stated, "Remissions do not depend on complete hypophysectomy nor are they correlated with the degree of suppression of urinary estrogen secretion."

Jessiman, Matson and Moore[8] reported 53 cases in which the course of the disease was significantly altered for the better in 60%. Some remissions have lasted over three years. Mortality was 2% with a major craniotomy procedure. They stated, "It is our belief, however, that it is not essential to obtain a microscopically complete hypophysectomy to achieve at least a temporary objective improvement in a hormone sensitive tumor." Although complete destruction of the pituitary can be done stereotaxically, one tries to destroy only the major portion of the anterior lobe. They noted that patients who responded, on an average, survived five times as long as those who did not with a useful life possible. They further stated that in "hypophysectomy failures" hormones and cytotoxic agents have been given with disappointing results. Four hundred milligrams of cortisone or 80 mg. of prednisone per day failed in all cases where it was tried as did testosterone and estrogens.

The Joint Committee on Endocrine Ablative Procedures in Disseminated Mammary Carcinoma[9] reported on 467 cases in which hypophysectomy had been performed. They set up rigid criteria to define objective remissions as follows, "only measureable decreases in one or more dominant metastatic areas by clinical or radiological examination without progression of any other metastatic lesions and no new foci of disease having appeared for 6 or more months, following the ablative procedure. All patients who showed progression of disease, and those with lesions remaining status quo were designated as failures—objective remissions which failed to endure for a minimum period of 6 months were classified with the failures."

In 467 cases of hypophysectomy, using these criteria, 31.3% of the patients had objective re-

missions averaging approximately two years; in 31.7% per cent of 404 cases of adrenalectomy the length of remissions was similar. Both procedures were major operations and both had a 9% mortality while the stereotaxic procedure can be performed as a relatively simple operation with practically no mortality and only five to seven days of hospitalization. They pointed out that Atkins (Lancet 1:1148, May 28, 1960) reported six months longer survival time in 70 hypophysectomized patients compared to 79 adrenalectomized patients. We would again point out hypophysectomy removes the "growth" hormone while adrenalectomy does not. The Joint Committee concluded, "The results indicate adrenalectomy and hypophysectomy are useful procedures in the palliation of patients with metastatic carcinoma of the breast."

At present patients can only be selected at random with those patients who responded to oophorectomy having a 91% chance of further remissions according to Ray;[3] those in the 60 to 75 year age group have a 70% chance of responding, and in overall cases a 50% chance of responding. Lemon[10] recently stated that estrone and estradiol 17B promote uterine and mammary growth and appear to stimulate cancer development in experimental animals. Estriol appears to curtail the growth-promoting effect of estrone and estradiol. Lemon stated that total excretion of these hormones does not differ in breast cancer patients and normal women. He found, however, that 17 of 24 cancer patients had subnormal estriol excretion; so the ratio of estriol to estrone and estradiol was altered in cancer. This change occurred in only nine of 30 noncancerous women. English workers[11] for some years have used a discriminant formula based on hormone excretions in selection of patients for operation. Hayward[12] of Guys Hospital, London, stated in a personal communication that since 1960 it has been the practice there to subject all patients with a negative discriminant or expected poor responders to adrenalectomy while positive discriminant or expected good responders are subjected to hypophysectomy. The staff believed hypophysectomy gives better results, but did not wish to refuse any patient therapy.

In 32 negative discriminant expected poor responders, only three or 9.4% had a remission while 21.9% had an intermediate result, and 68.8% were failures. In 35 patients with positive discriminant or expected good responders with hypophysectomy 16 or 45.7% had a remission while 22.9% had an intermediate result and 31.4% were failures.

Report of Case

A 57 year old, known diabetic for six years with glaucoma, noted a lump in the right breast for three weeks. Radical mastectomy was performed on Aug. 30, 1961, after biopsy showed carcinoma. In six glands in the axilla there was almost complete replacement of the lymphocytic tissue by malignant cells. She did well until July 1964 when she complained of dyspnea on exertion for one month and at rest for one week. A node in the axilla showed carcinoma; chest x-rays showed bilateral pleural effusion, 650 cc. of fluid being removed from the right side of the chest and 350 cc. from the left side. Both fluids showed carcinoma cells. The patient was given estrogenic therapy for nine months: Stilbestrol 5 mg. daily; five treatments of Fluorouracil; Mitomycin C; Atabrine in the chest and nitrogen mustard, none of which controlled the dyspnea. Thoracentesis was required on an average of every three days.

Her life expectancy was estimated at two to four weeks at the longest by the chemotherapist when she was referred to me for stereotaxic hypophysectomy. The transfrontal route used by Hastain-Bennett,[4] Cooper[13] and Mundinger and Riechert[14] among others, with the incision behind the hair line on the right at the coronal suture, was used. The coagulating apparatus of Spiegel and Wycis[15] was used for destruction, guided by Bertrand's stereotaxic device[26] which we have used in the treatment of Parkinsonism and which is accurate in its placements to one-half millimeter. On September 17 the operation was performed under local anesthesia with the patient sleeping from sedation. In the operating room a burr hole was placed and the incision closed. Later the patient was taken to x-ray. There the stereotaxic device was applied, again under local anesthesia, with the patient drowsy or asleep from sedation, and pituitary destruction carried out (figs. 1-4).

The patient was up and about the next day, taking normal amounts of fluid. (In the major craniotomy procedure, diabetes insipidus of varying degrees is almost always present for several weeks and occasionally persists.) She was given cortisone preoperatively and maintenance doses of 37.5 mg. daily postoperatively. No ill effects from the operation were noted; the thoracentesis decreased to only one every eight to 14 days, but the fluid did not clear completely. Other studies will be reported elsewhere with other cases. She was improved, so she stated, and clinically appeared to be.



Fig. 1. — Head fixed in stereotaxic device with pins behind the ears and at the lateral canthus.

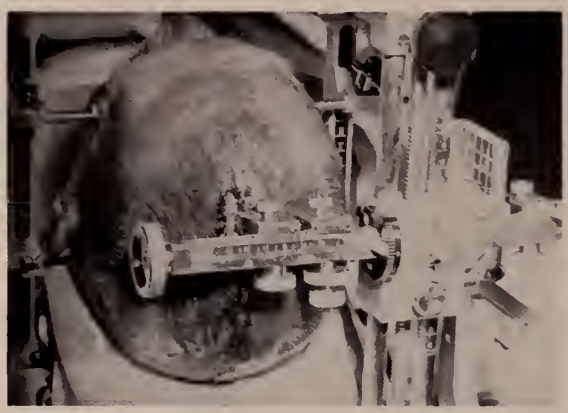


Fig. 2. — Shows the centimeter-squared grid superimposed between the head and the x-ray plate. This permits aiming the electrode at the target point outside the head.

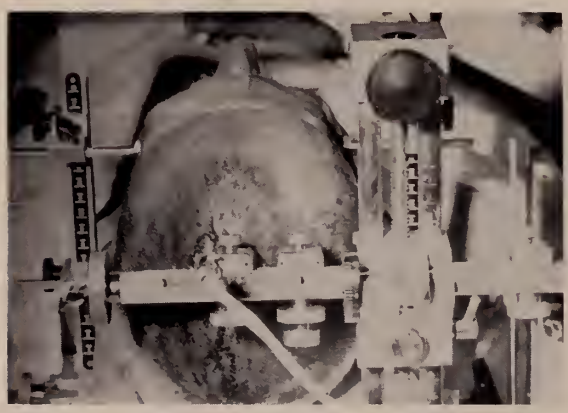


Fig. 3. — The electrode is then placed precisely to the target point by insertion in the bar. In this instance the electrode has been placed on the left.

On Jan. 16, 1965, she was readmitted and transferred to the oncology service on January 21, where two courses of quadruple treatment of 5 Fluorouracil, Mitomycin, Vinblastive sulfate and Cytoxan were given with no change in x-ray findings of the pleural effusions although the dyspnea had improved and thoracentesis was no longer required. She was discharged on March 8, and was still up and about, considerably improved as regards dyspnea both she and her husband thought, when she died in her sleep on March 19. She then had survived six months with considerable symptomatic improvement although her life expectancy had been thought to be only two to four weeks, and she was in such poor shape one would have been afraid to give her a general anesthetic.

Ray[3] reported that in many cases pleural effusion will clear completely in responding patients. Jessiman, Matson and Moore[8] believed the earlier use of hypophysectomy is indicated.

Diabetic Retinopathy and Hypophysectomy

Since Houssay and Biossotti[27] in 1930 noted ablation of the pituitary helped pancreatectomized animals, scattered reports of human work have appeared. Chabanier[28] in 1936 performed the first hypophysectomy on a diabetic. In 1953 Poulsen[29] reported improvement of diabetic retinopathy in a patient in whom Sheehan's syndrome of hypopituitarism had developed. Luft[30] in 1955 reported encouraging results with hypophysectomy for diabetic retinopathy.

Today in diabetic retinopathy hypophysectomy offers almost the only method of preventing blindness in many patients. Diabetes ranks as the third leading cause of blindness and the eighth leading cause of death, according to Reaven and Power.[31] They stated that there are two types of diabetes. The one with onset in childhood, usually before 15 but occasionally through 25 years of age, is the unstable form resulting from failure of the islets of Langerhans in the pancreas to supply insulin. This is the most severe type and is treated by supplying insulin. In the other type onset is usually after age 40. The patients have higher than normal levels of "insulin activity" in the blood while excess sugar is noted. This type is treated by the sulfonylureas which promote release of insulin.

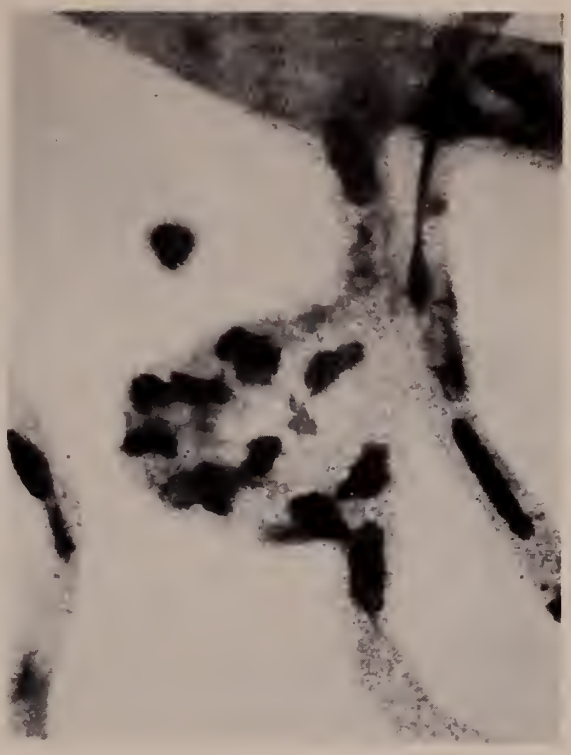


Fig. 4. — Shows the electrode in position in the anterior pituitary lobe. A selective destruction of the anterior lobe only is the result desired.

Retinopathy develops in both types but more in the patients of younger age with earlier onset. In retinopathy small aneurysms, hemorrhages, exudate and new blood vessels diminish or disappear with hypophysectomy. Advanced changes such as fibrosis, gliosis, retinal separation and glaucoma remain static or progress.[32] Caird[18] believed that patients of older age with later onset have a poorer prognosis in retinopathy.

Cogan and Kuwabara[25] proposed the theory of vascular shunts with loss of tone of certain retinal vessels permitting areas of the retina to be starved of blood as the mechanism of the retinopathy. By trypsin digestion of the retina they differentiate normal endothelial cells which line the lumen of the retinal capillaries from "mural" cells in the wall of the capillaries. They believed mural cells control the tone of the capillaries. In diabetes mural cells die. They become "ghosts" and balloon or blister out to form microaneurysms while other capillaries lose tone, dilate, become oversized, shunt the blood, hemorrhage and starve the rest of the retina while retinal detachment and glaucoma may form secondarily (fig. 5). This probably represents an oversimplification of many unknown factors but has pathological backing.

Root[16] found retinopathy developed on an average after 17.4 years in patients whose diabetes developed before age 20. He reviewed 847 cases of diabetic retinopathy and found uremia in more than 50%. Collyer and Hazlett[17] in reviewing 100 cases of diabetes of juvenile onset found retinopathy in 80%. Caird[18] studied 189 eyes with good vision (6/18 or better) but with diabetic retinopathy and compared their visual prognosis with 169 diabetic controls without retinopathy. The vision of patients with diabetic retinopathy became impaired (6/24-6/60) at the rate of 7.5% annually with 35% at five years compared to 2.4% of controls at five years while 3% of patients with retinopathy and good vision became blind annually with 14.5% blind at five years compared to 0.3% for controls. In diabetic patients with retinopathy and impaired vision (6/24-6/60) 13% became blind annually compared to 1.3% of controls and 50% were blind in five years. One can prognosticate that of diabetic patients with retinopathy but good vision, 35% will have serious impairment in five years while in diabetic patients with retinopathy and visual



Microaneurysm induced in retinal capillary of dog (above) shows similarities to damage in patient with long-standing diabetes.



Figure 5.

impairment, 50% will be blind in five years. This progressive loss of vision can be stopped in many cases by hypophysectomy.

Gonda[19] reported 10 cases in which hypophysectomy was performed with nine (90%) having objective visual improvement. Pazianos, Pearson and Ray[20] reported 36 cases with 70% "striking improvement" after operation and objective improvement occurring as early as two months (figs. 6,7). In one patient improvement had been maintained for seven years. Lawrence[7] treated 109 patients with heavy particle suppressive doses to the pituitary with 55% benefited as judged by clearing of the retinal lesions of microaneurysms, hemorrhages and exudate. Svien[6] reported operation on 28 patients with no mortality and 55% improved. Fager[21] operated on 62 patients with 52 followed long enough to report; improvement was noted in 24. If the macula is already severely damaged, vision probably cannot be saved. Vannus, Hernberg, and Bjorkesten[22] operated on 10 patients, all of whom were blind in one eye and vision was seriously threatened in the other eye. Seven were improved and have maintained this improvement for over 10 years.[23] Nearly all authors reported that insulin requirements were frequently reduced by one half after the operation. Whedon[24] regarded diabetic retinopathy the most serious complication of diabetes. Twelve of 13 patients operated upon showed "unequivocal" beneficial changes in vision.

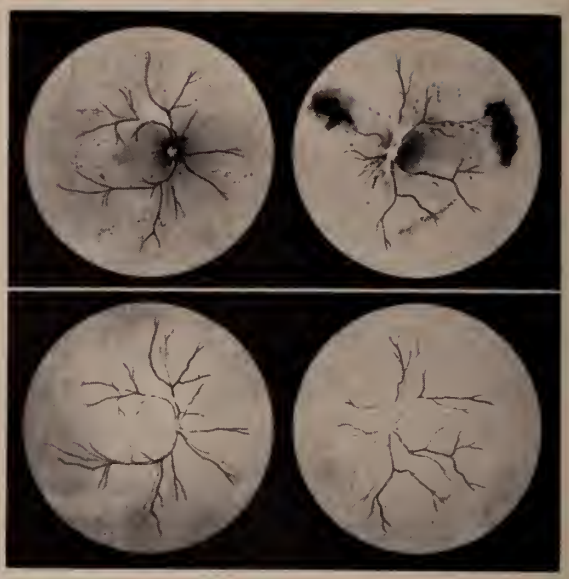


Fig. 7. — Before hypophysectomy (top), both eyes show microaneurysms and exudate; eye at right has hemorrhages in vitreous. After operation (bottom), defects have almost disappeared.

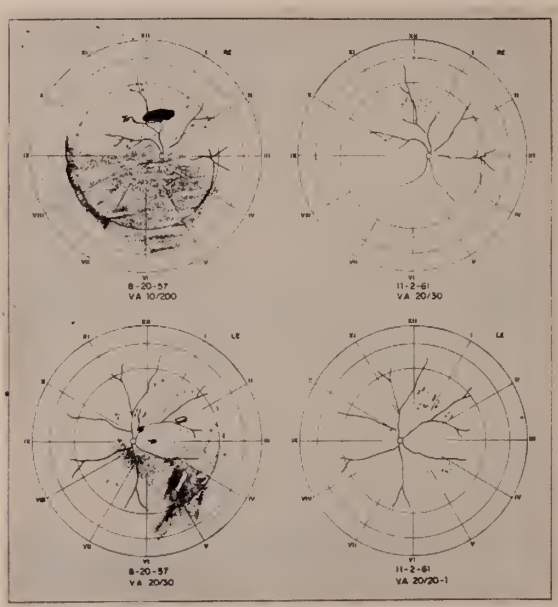


Fig. 6. — Stippled areas represent preretinal and vitreous blood; solid black areas, vitreous hemorrhages; small accentuated black dots, microaneurysms; and enclosed stippled areas, retinal exudates. Visual acuity in right eye improved from 10/200 on Aug. 20, 1957, to 20/30 on Nov. 2, 1961 (left). Visual acuity in left eye improved from 20/30 on Aug. 20, 1957, to 20/20-1 on Nov. 2, 1961 (right).

Conclusion

Hypophysectomy with removal of the "growth" hormone will cause remissions in patients with metastatic cancer of the breast, some of which may last five years, in approximately 50% of random-selected patients, in 70% of the 60 to 75 year age group, and in 90% of those who respond to oophorectomy.

Hypophysectomy can stop the progress toward blindness in diabetic retinopathy in from 50% to 85% of patients. In many, visual improvement will be noted.

The stereotaxic method of hypophysectomy transfrontally can be performed under local anesthesia with the patient asleep from sedation on the poorest risk type of patient with little morbidity or mortality. Complete hypophysectomy is neither necessary nor desirable to secure a beneficial result.

This operation is not a "cure," but does offer worth while palliation to patients with these fearful progressive diseases.

References are available from the author upon request.

401 Miracle Mile.

Symposium:

The Recurring Urinary Calculus



Editor's Note: Under the direction of Truett H. Frazier, M.D., of Orlando, the Florida Urological Society has prepared the following information concerning the recurring urinary calculus. We are pleased to publish it as a symposium on this important subject.

William H. Boyce Jr., M.D., Professor and Chief, Section on Urology, Department of Surgery, Bowman Gray School of Medicine, Winston-Salem, North Carolina, who is recognized for his interest in this subject and the experimental work which he is at present conducting, has contributed a discursive editorial, (Page 128) which completes the symposium.

It is the belief of the editorial staff of The Journal of the Florida Medical Association that presentations such as this will help us to practice better medicine. Dr. Frazier and the contributing authors are to be congratulated for their efforts in our behalf.

T.M.

Etiology and Incidence of Renal Stones

TRUETT H. FRAZIER, M.D.
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Renal stones are common in occurrence and their causes are not thoroughly understood by anyone. This statement seems at first glance to all but close the discussion under this heading; however, a brief review and understanding of what is known about the etiology and incidence of renal stones should prove beneficial to the average practitioner of medicine.

Certain factors have long been recognized as contributing, at least in part, to the formation of renal calculi and might be listed as follows:

URINARY STASIS.—Obstruction due to any cause (stricture, prostatic hypertrophy, aberrant blood vessel, kinking, external pressures, neurological dysfunction, et cetera) commonly leads to stone formation. If the urine, being composed largely of solvent and solute, passes rapidly and uninterrupted from the kidney to the lower urinary tract, it seems logical to assume that the solute would have less opportunity to settle out and form stone than it would in a slow, sluggish stream often seen in urinary stasis.

DEHYDRATION.—In some parts of the world where relative dehydration is prevalent, as in Florida, the incidence of renal stones (oxalate) in the absence of other contributing causes is common. The normal kidney is capable of putting out a supersaturated solution without stone formation taking place; however, a supersaturated urine in the presence of other predisposing factors, such as stasis and infection, is thought to contribute to renal stone formation.

Infection.—Brief, acute infections likely contribute little to stone formation whereas chronic infections, many times associated with urinary stasis, urea-splitting organisms, and alkaline urine favor the formation of phosphate and carbonate stones.

Hyperparathyroidism.—It has been estimated that from 4 to 5% of the cases of renal stones might be traced to this disease. In some cases of hyperparathyroidism, calcium salts may be deposited in the renal parenchyma (the walls of the tubules and collecting ducts) as well as lead to stone formation in the renal calyces. This is due to the decalcification of the bones and excessively high concentration of calcium in the urine. The incidence of this disease is rather rare in the experience of most of us.

Abnormalities of Metabolism.—Cystine normally is not present in the urine; however, it occurs in the condition known clinically as cystinuria, which is caused by faulty protein metabolism. When present, it is likely to form stones in an acid urine. The condition is rare, occurring in one out of every 15,000 persons with only 2 to 3% having stone formation. Xanthine (an intermediary product of purine metabolism) stones are extremely rare. Persons with a high blood uric acid, whether associated with gout or not, are frequently candidates for uric acid stone formation, particularly in the presence of an acid urine. Uric acid stones have been reported by Campbell to be the most common stone seen in infants and small children.

Vitamin Deficiency and Diet.—Vitamin A deficiency has been shown to produce keratosis of the renal epithelium which serves as a nidus for stone formation in the experimental animal. It is also thought that under certain circumstances vitamin A deficiency may contribute to stone formation in man. Neither crystalluria nor the hardness of drinking water per se seems to play an important part in renal stone formation. Some investigators conclude that excessive habitual ingestion of citrus fruits, high in alkaline ash and low in protein and vitamin A (acid ash), contributes to a striking increase in the incidence of phosphatic stones in the citrus areas of Florida and California.

Biochemical Factors.—Normally, crystalloids and colloids exist in the urine in acceptable proportion. Any factor which disturbs the crystal-colloidal equilibrium is said to be an etiologic factor in stone formation.

Familial Influence.—There seems to be no increased familial incidence in stone formation except where cystine stones are concerned.

One is impressed with the fact that stone disease in the urinary tract has been recognized clinically since the days of the ancient Hindus and Egyptians, and yet, despite much laboratory and clinical investigation by capable men, an understanding of the basic causes of stone formation still eludes us. I believe that the diligent efforts of these investigators will in the not too distant future bear fruit. Until that time we should bear in mind the importance of the factors mentioned.

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Diagnosis of Stone Disease

Robert N. Webster, M.D.
TALLAHASSEE

Suspicion may be the most important single factor in making a diagnosis of stone disease. To steal an old aphorism, the same might be said of calculus disease of the urinary tract as has been said of syphilis when it was called "the great imitator."

A careful history along with a high index of suspicion probably is of the greatest help in making a diagnosis of stone disease. It goes without saying that a history of stones in the past should certainly alert the physician. For the purposes of this discussion, the urinary tract will be

divided into three divisions: first, the kidney, including the renal pelvis; second, the ureter; third, the bladder.

Stones within the collecting system of the kidney and calcinosis of the parenchyma of the kidney are often silent for prolonged periods of time. Occasionally the patient who presents himself with the findings of unexplained microscopic hematuria, or microscopic pyuria and vague complaints may not have at any time been aware of pain in what we generally have come to accept as the renal region, namely, the general area of the costovertebral angle. When the calculus enters the renal pelvis, the patient usually becomes aware of it almost immediately, particularly if the stone is of such size as to act like the proverbial ball in a funnel, giving rather acute symptoms as long as the pelvis remains obstructed. Rather dramatic relief may occur when the patient assumes the recumbent position and the calculus moves permitting unobstructed drainage of the kidney.

Calculi within the ureter ought to be rather clearcut but many times they are not. Again, a high index of suspicion is of great help. Positive urinary findings may or may not be demonstrated. In the event of unilateral ureteral calculus and complete obstruction of the ureter, the urine oftentimes is microscopically clear since no urine is being collected from the affected side. One often considers the classical pain of ureteral colic as that commencing either in the scrotum or labia, and extending superiorly and laterally into the flank and the region of the costovertebral angle on the affected side. At other times the onset is more insidious. This depends to a great extent not only on the size of the calculus in relation to the size of the patient's ureter, but also on the configuration of the calculus, whether it is smooth, rough, or sharply hooked.

Again, this may represent the great imitator in that many patients have been subjected to abdominal laparotomy with a preoperative diagnosis of appendicitis, and in some instances, bowel obstruction because of a small calculus obstructing a ureter. The reflex ileus that accompanies ureteral colic can simulate small bowel obstruction. Many times an unsuspecting physician reports a negative KUB, plus an essentially negative urine (which either does not have red cells because of complete obstruction of the affected side or a carelessly examined microscopic specimen of the urine) that would tend to eliminate the diagnosis of ureteral calculus too quickly. Once the suspicion has been aroused, intravenous and/or retrograde pyelograms will usually make the diagnosis. I am sure that many of my colleagues have been embarrassed, just as we have, by the occasional small, nonopaque calculus which is missed despite all of these efforts. The patient gradually gets better and then comes to the office the next week and hands you a small calculus, after you have told him that in all probability he does not have one.

Calculus disease of the bladder gives the urologist a considerable advantage, in that usually there will be, not only urinary findings, but urinary symptoms making this rather obvious. Severe bladder irritability with persistent low grade infection, in the absence of clinical evidence of pyelonephritis, should make one suspicious. Primary bladder calculi are rather seldom seen in the absence of obstruction of the bladder neck unless there had been a previously introduced foreign body. In some rare situations, a small ureteral calculus might pass into the bladder and fail to pass the rest of the way, thus forming the nidus for progressive bladder stone growth. In this situation, the KUB film with proper patient positioning on the x-ray film plus the urinary findings usually will make the diagnosis. Once the patient is seen by the urologist, the cystoscope is of immeasurable help to confirm the diagnosis.

In summary, no attempt has been made to present anything new on this rather timely subject, but merely to present some of the findings which we tend to use in our thinking in the practice of everyday urology. The careful history and a high index of suspicion are probably the two most vital factors in establishing a diagnosis of stone disease of the urinary tract. They will usually lead the physician to arrange for a complete urological work-up which in turn usually results in an accurate diagnosis.

1207 Hodges Drive.

Medical Treatment of Stone Disease

John T. Karaphillis, M.D.
CLEARWATER

Treatment of patients who have had a renal calculus is a challenge and a responsibility that rest with both the urologist and the attending physician. In spite of our inadequacies in the pathophysiology of stone, certain features are known which contribute to the adequate management of stone disease.

The success of treatment depends on the accuracy of the history obtained from the patient and his dietary habits. The essential work-up should include urinalysis, pH of the urine, urine culture, excretory urograms, serum calcium, calcium content of the urine, phosphorus, uric acid and analysis of stone removed or passed. At times if excretory urography is not diagnostic, one should then resort to retrograde pyelography for the detection of obstructive changes in the ureters and urethra.

If the investigation reveals that a stone is uric acid then we should alkalinize the urine and institute forced hydration, so that an output of 1,500 to 2,000 cc. a day should be excreted. Uric acid is soluble in a pH of 7 or higher, and to accomplish this adjustment, sodium bicarbonate or potassium citrate can be given. Potassium citrate is probably the more efficacious of the two; however, sodium bicarbonate is easier to administer.

For cystine stone the condition is usually familial, and is often found in more than one member of the family. The management of this type of stone is, as with uric stone, alkalinization of the urine. Larger quantities of alkali must be given to raise the pH above 8. Fruit juices such as citrus fruit juices alone, unless taken in large quantities, are not of real value in alkalinizing urine.

Chronic infection of the urinary tract leads to stone recurrence, and every effort should be made to eradicate the infection. Urea-splitting organisms alter the pH of the urine, thus favoring precipitation of urinary salts. Recently, work has been completed that demonstrates a link between intestinal bacteria and the matrix of renal stones.

The treatment of infection requires continued therapy for several months with sulfonamides or other appropriate drugs, and the alteration of the pH with low citrate diet, supplemented with ammonium chloride, methionine or cranberry juice.

If no error of metabolism can be detected, certain general measures are then appropriate in the management of the patient with stone formation, such as forced hydration and diminution in the intake of dairy products. Restricting salt intake will reduce calciuria.

Stone analysis should be carried out when possible. For those stones composed of phosphates or carbonates, the high vitamin A, acid-ash diet is recommended. For those calculi of oxalate structure, the high vitamin A, low oxalate diet is used. The fundamental purpose of the diet is to adjust the pH of the urine.

Salicylamides are still in use in many places. Their value in the prevention of stones remains doubtful. Dissolving stones in the kidney or ureter is impractical. The use of Renacidin for dissolving renal stones has been discontinued because of reported deaths, and for oral administration we know of no drug that will dissolve stones. Medication to dissolve stones still awaits discovery.

430 Pinellas Street.

Surgical Treatment of Urinary Stones

William R. Daniel, M.D.
ORLANDO

In this brief discussion of the surgical treatment of urinary calculi we must confine our considerations to broad principles rather than attempt specific instructions which are incomplete even in textbooks on the subject. Surgery should be performed only in those cases in which the risk of nonsurgical treatment offers the greater hazard. It is obvious, therefore, that a urological problem in a young, good-risk patient might require an entirely different approach from a similar condition in the elderly or poor-risk patient. In the treatment of urinary tract calculi the physician's primary objective is the conservation of renal tissue. It must be realized, however, that patients live longer, healthier lives with only one good kidney than with one good kidney and one bad kidney. For our purposes let us approach the following problems with the assumption that they exist in a good-risk patient with a reasonable longevity.

Small renal stones, even if multiple, require no surgical treatment if no complication develops. These small stones may require surgery if significant pain, infection, or bleeding occurs. If the stone is solitary, it is generally best to await its becoming impacted at the ureteropelvic junction before exploration is attempted because locating it is so much more certain there. Stones larger than one and one-half centimeters in diameter usually require removal by pyelolithotomy or nephrolithotomy if the kidney is healthy. When a staghorn calculus or multiple calculi with persistent infection exist in one kidney and the opposite kidney is normal, the patient's condition is generally improved by a nephrectomy. Bilateral staghorn calculi present a most disheartening situation and are generally better left alone even though infection is nearly always present. Occasionally, a bold approach—complete removal of the stones from each kidney—is warranted. In these instances one usually performs a toilet first on the side which is symptomatic. When neither side is symptomatic, the kidney with the poorer function is operated upon first. The patient must be allowed to recover completely from this operation before being subjected to further surgical therapy. Partial nephrectomy may be used to rid a kidney of its stone-bearing segment.

Patients with ureteral calculi which are of small enough size so that their spontaneous passage is likely should not be subjected to operation unless some complication occurs. Prolonged and severe pain, significant urinary tract infection, or total obstruction over a period of two or three weeks affords sufficient reason for surgical intervention. Preference for transurethral instrumentation or open surgery varies tremendously among urologists, but we are reluctant to attempt stone basket extraction of stones above the lower third of the ureter. Even small ureteral calculi above the lower border of the pelvic brim are best treated by ureterolithotomy should operation become necessary. Occasionally, in a very septic patient it is necessary to drain the kidney via ureteral catheter for a short period before proceeding with definitive surgery. Antibacterial therapy must be aggressive in these instances. If, for any reason, a ureteral stone cannot be removed, some diversionary procedure well above its point of impaction may become necessary.

Bladder calculi nearly always require removal. They may be removed by transurethral methods if small enough to be evacuated or crushed by lithotrite. If not, or if multiple calculi are present, it is generally safer to perform a cystolithotomy.

It is axiomatic in the treatment of urinary calculi that any obstruction must be removed to prevent stasis, infection, and stone recurrence. Ureteral reflux infection must be treated vigorously when it exists.

415 Briercliff Drive.

Prevention of Stone Formation

Carey N. Barry, M.D.
FORT MYERS

Prevention of stone formation must encompass two basic considerations: prevention of recurrence of calculi in persons who have passed calculi or had them removed surgically, and prevention of calculus formation in persons likely to have stones form because of other diseases such as orthopedic fracture, neurological disability, temporary and permanent, peptic ulcer and gout.

In my experience the most important factors in prevention are correction of obstruction, eradication of infection, adequate fluid intake, adjustment of urinary pH depending on stone analysis, and omission of milk and major milk products when indicated. Obstruction at whatever level must be corrected. It is generally accepted that upper tract obstruction is a major factor in stone formation. All too often so-called remote or lower tract obstruction is overlooked. Anterior urethral obstruction as well as posterior urethral obstruction from whatever cause occurs commonly. Stenosis of the urethral meatal and navicular fossae is extremely common. Eradication of infection should be culturally proved and follow-up should be as long as necessary to insure an aseptic state. It is difficult to eradicate infection when obstruction coexists.

Adequate fluid intake will vary from person to person. It is obvious that the bank executive in his air-conditioned office will not require as much fluid as will the laborer; 3,000 cc. of fluids might be adequate for the former and woefully inadequate for the latter. The person who loses large volumes as perspiration, and it may be 3 to 5 quarts, should be shown what dilute urine looks like and advised to force fluids to maintain the light yellow color. I recall one patient who insisted he was getting an adequate intake until he submitted a 24 hour specimen of 676 cc. for urine calcium excretion studies. All my preaching had been to no avail until this fact came to light. As to pH adjustment, the urine should be kept on the acid side for all the common stone types except those of uric acid. Some bizarre conditions will not fit within this oversimplification, but they occur rarely.

In my experience, most patients will not adhere to acid or alkaline ash diets and they are not too reliable or practical. Acidification can be achieved with potassium acid phosphate and if current theories hold true, aid in prevention through pyrophosphate protection. Cranberry juice may also be used. In the patient with gout in whom uric acid stones form or may form, Polycitra and low purine diet are helpful. Milk and all its major products such as cheese in all forms and ice cream should be completely omitted in patients with calcium phosphate and mixed calcium stone formation. The subject of prevention of recurrence would not be complete without mentioning parathyroid adenomata or hyperplasia as a cause. This factor should always be considered, investigated, and if proved, often a difficult task, surgical removal of tumors or hyperplastic glands should be performed.

Too often patients who are potentially subject to stone formation because of other diseases are not adequately protected. In this group of patients are those with fractures, in casts which do not permit ambulation, and the neurological cripples, permanent and temporary. These patients should omit milk and its major products. Fluids should be forced to insure adequate output. They should be given an acidifying antiseptic such as potassium acid phosphate and ammonium mandelate at the outset of the injury and maintained on this regime.

The patient with peptic ulcer disease is potentially a subject for stone formation. Hyperparathyroidism frequently enough has peptic ulcers in association. Increased intake of milk compounds the problem enough, but when anticholinergic drugs are used, urinary obstruction may occur or be increased.

Gout and its stone diathesis has been covered sufficiently for this brief discussion in the first major heading.

2161 McGregor Boulevard.

Clinicopathological Conference

University of Florida College of Medicine

D. R. Shanklin, M.D., Associate Professor of Pathology and Pediatrics.
William B. Weil Jr., M.D., Associate Professor of Pediatrics.

This was the second and final admission of a 10 year old Negro female child who was admitted 21 days prior to death for physical therapy to relearn how to walk.

Present Illness. — Approximately nine months before her first admission, 14 months prior to death, she stubbed her toe and an erythematous macular sore developed on the pad of the left second toe which spread to involve the entire end of the toe and a few days later turned black, firm, and tender. Similar events occurred over the low right pretibial area and on one finger. She had fever intermittently and minimal edema of the hands and feet. Two months prior to her first admission she noted itching of the feet and toes and mild fever, anorexia, and loss in weight developed, followed by progression of the erythema, pain, and blackening of the toes with tenderness and drying. On her first admission the blood pressure was 100/75 mm. Hg with a pulse rate of 140 per minute. She was a poorly nourished Negro female child with gangrene of the digits of the hands and feet. There were no murmurs on auscultation of the heart. There was a slight tachycardia. No masses were felt in the abdomen and no arthritis was demonstrated.

Laboratory Data on Initial Admission.— The hemoglobin was 10 Gm. per hundred cubic centimeters, and the white blood cell count was 12,500 per cubic millimeter. A platelet count of 620,000 per cubic millimeter was recorded. The stool guaiac test was positive and Ascaris ova were present. A sickle cell preparation was negative. The urine was negative for arsenic, antimony, bismuth, and mercury. The anti-streptolysin O titer was 11.5 Todd units. Cryoglobulins were negative. The serological test for syphilis was not made. Bone marrow culture was negative. Blood culture was negative. Serum electrophoresis revealed 7.8 Gm. of protein with albumin 33 per cent; alpha-1 globulins 5.1 per cent; alpha-2 globulins 10.4 per cent; beta globulins 9.1 per cent; and gamma globulins 42.4 per cent. Urine tests for 5-hydroxyindolacetic acid were negative. A barium swallow test was within normal limits. Shortly after admission a bilateral transmetatarsal amputation was performed. The amputation site of the right foot required additional debridement and the left middle finger was also debrided. The patient received antibiotics for local infection and was discharged after 68 hospital days.

Interval History.—Since discharge she had had no pain, numbness or erythema. The temperature had ranged between 39 C. (102.2 F.) and 39.5 C. (103.1 F.) during clinical visits. There were no symptoms referable to other systems and no family history of a similar condition.

Physical Examination on Second Admission.—The temperature was 39.5 C. (103.1 F.), pulse rate 130 per minute, respirations 26 per minute, and blood pressure 120/65 mm. Hg. The patient presented a cushingoid appearance. Examination of the ocular fundi revealed a decreased arterial size, but no nodularity. Examination of the chest was unremarkable. The patient was thought to have a slight cardiomegaly with sinus tachycardia. The abdomen was protuberant. There was no tenderness or fluid wave. The liver was palpable 1 cm. below the costal margin. The spleen was not palpable. Examination of peripheral pulses revealed bilateral radial and brachial pulses with a slightly decreased radial pulse on the left. The femoral pulses were equal and adequate bilaterally. The popliteal pulses were palpable, but

thought to be diminished. No posterior tibial or dorsalis pedis pulses were palpable. The distal extremities were cold to touch and 2 plus bilateral edema of the lower extremities to the level of the knee was noted.

Course in the Hospital.—The patient continued to be febrile, spiking temperatures daily up to 40 C. (104 F.). The stated purpose of the hospitalization was set aside because of continuing degeneration in her clinical status. An electrocardiogram taken two days after admission revealed ventricular hypertrophy, nonspecific ST changes, a prolonged QTc interval and a relatively short PR interval. Chest x-ray revealed a marked generalized enlargement of the cardiopericardial silhouette thought to be due to pericardial effusion. A follow-up film after tap of the pericardial sac revealed air in the pericardium with some decrease in size of the effusion. Urinalysis, which was otherwise unremarkable initially, revealed a specific gravity of 1.015 with a trace of protein. The hematocrit reading was 26 per cent and the white blood cell count was 12,800 with a normal differential count. Five days after admission the white cell count rose to 38,000 with a relative neutropenia. The stool was positive to guaiac test. The blood urea nitrogen and electrolytes were normal. Cholesterol was 177 mg. per hundred cubic centimeters. One sickle cell preparation was negative and four LE preparations were negative. Six blood cultures were negative.

A pericardial tap removed 450 cc. of serosanguineous fluid which clotted immediately. No organisms were seen on gram stain of the pericardial fluid. No acid-fast bacilli were seen on smear of the pericardial fluid. Urine culture grew out Escherichia coli and coagulase-negative hemolytic staphylococcus. The anti-streptolysin O titer was 100 Todd units. Cold agglutinins were negative. C-reactive protein was 1 plus; Salmonella A, B, D and E were negative; Salmonella C was positive 1:40 and Salmonella d 1:640 plus. The Brucella test was negative. Proteus OX 19 was negative and para a and para c were negative with para b at a titer of 1:40. The stool was negative for ova and parasites on two occasions. The albumin:globulin ratio was 0.6:1. Periorbital edema was noted 10 days prior to death and a repeat tap of the pericardial sac removed an additional 225 cc. of amber-colored fluid. The gangrene of the fingers, particularly on the right, was noted to increase. Otherwise the patient's condition remained unchanged with spiking temperatures that failed to respond to therapy. The patient began to fail and repeat electrolyte studies on the day prior to death revealed a sodium of 125 mEq., with a chloride of 82, carbon dioxide of 24 and calcium 7.6. The patient became semicomatose, and had a generalized seizure treated with phenobarbital and Dilantin. The terminal event was characterized by marked retraction and a sharp fall in blood pressure. Permission for autopsy was obtained.

Dr. William B. Weil Jr. (Associate Professor of Pediatrics):

In summary, this is the case of a 10 year old Negro female child whose history goes back slightly over a year and whose illness began rather abruptly with a lesion of an extremity which progressed from erythema to gangrene over a relatively brief period of time. This process was not limited to one area, but occurred on the other lower extremity and on one upper extremity in the ensuing two months. She was admitted to the hospital nine months after the onset of her problems and at that time the only findings of note were a mild anemia, some blood in the stool, and a markedly elevated gamma globulin level. A single platelet count was somewhat elevated. After her discharge, she was readmitted three weeks before her death, and at that time had a cushingoid appearance. One might well assume that she was treated with steroids in the interim. It is important that she had peripheral pulses in both radial and brachial arteries. The femoral and popliteal pulses were also present and only the posterior tibial and dorsalis pedis were absent. Other evidences of vascular insufficiency in the lower extremities were the cold temperature and the edema.

In the hospital for the final time, she had a pericardial effusion and some additional signs of cardiac involvement which are difficult to evaluate in the face of the effusion. The white blood cell count rose to 38,000, but she had no evidence of infection other than a persistent elevation in one of the Salmonella antigens. She then expired with some chemical abnormalities which are not particularly diagnostic.

This case allows me to discourse briefly on the diagnostic methodology of medicine and the ap-

plicability of computer technology to this methodology. A number of publications have appeared in which the diagnostic capabilities of computer systems have been discussed.[1,2] It was important in the preparation of computer programs for diagnosis to understand more clearly how the physician approaches a problem case. I shall illustrate this by using a computer-like approach with this case as I believe it is representative of the way that the majority of physicians actually approach such a problem, though they may not always realize it. I should state parenthetically that such an approach ordinarily would not be useful in the clinicopathological setting, as the pathologist often is tempted to present the most atypical, unusual, and nonstandard case in order to confound the clinician and demonstrate the glory of pathology as a specialty. In this case, however, I am certain that Dr. Shanklin is above such tactics.

One way to approach a problem of this type would be to select some sign, symptom, or laboratory finding and then examine all possible diagnostic categories which would be applicable. One then takes another sign, symptom, or finding, and eliminates those conditions which are not compatible with the two items. Then one adds additional items further eliminating conditions which do not meet the added criteria until one is hopefully left with one or a few diagnostic possibilities (table 1). At other times, the unique grouping of certain signs and symptoms suggests specific disease; however, this simply reflects the fact that the mind has operated very rapidly to exclude the illogical possibilities as mentioned.

Table 1. — Accumulation of Points in the History Favoring or Against a Given Diagnosis

Diagnoses Considered	Factor Favoring	Factor Against
Vascular diseases		
Takayasu's syndrome		x
Arteriosclerosis, post diabetic		xx
Medial calcinosis		x
Thromboangiitis obliterans (Buerger's disease)	x	xxxxx
Raynaud's disease	xx	xxx
Syphilis	?	x
Polyarteritides	xxxxx	xx
Lupus erythematosis (SLE)	xxx	xx
Hematologic diseases		
Secondary thrombocytoses*		x
Primary thrombocytosis	x	x
Cryoglobulinemia		x
Embolic diseases		
Subacute bacterial endocarditis (SBE)	x	
Mural thrombosis		x

* Six causes mentioned in the text.

From a computer's point of view and probably for most physicians, the first sign, symptom, or finding which is used for determining a differential diagnosis is one which is striking in the particular case and one which has perhaps the shortest list of possibilities. Fever was a prominent finding through much of this history, but the possibilities for the differential diagnosis of fever are so extensive that one would be tempted to use an alternative sign.

In this case, we might choose the evidence of gangrene or severe vascular insufficiency. This presumably would give a shorter differential list and hasten our arrival at a possible diagnosis. In considering the possibilities that could lead to peripheral ischemia, there are three major categories: vascular, hematologic, and embolic. Beginning with the vascular, we might group these into three divisions—vascular problems of large vessels, medium vessels, and small vessels. At this point, we should realize that we assumed at least one item in our thinking which we have not expressed and which the computer would require to parallel our approach to this diagnosis. Incidentally, this omission illustrates one of the major problems in computer programing and that is the exclusion of certain subtle assumptions which the human mind makes unconsciously or automatically. The information involved is the fact that this is not only peripheral ischemia but is peripheral ischemia of multiple sites, and these sites are in physically noncontiguous areas. In other words, we are dealing with a generalized process and to arrive at the proper grouping of diagnoses, we would have to add this to our definition of peripheral ischemia.

Under these circumstances, about the only large vessel disease that we need to consider would be so-called "pulseless disease" or "Takayasu's syndrome." In the grouping of diseases of medium vessels, we would have to include arteriosclerosis, particularly as a complication of diabetes. Second would be medial calcification. Third would be thromboangiitis obliterans (Buerger's disease). Fourth would be primary Raynaud's disease. Fifth would be syphilis, and sixth would be the polyarteritides. Among the conditions involving small vessels only, the major consideration would have to go to systemic lupus erythematosis (SLE).

Under the hematologic classification, we would have to think of those conditions first that produce secondary thrombocytosis which would include (a) sarcoid, (b) polycythemia, (c) infections, (d) hemorrhage, (e) malignancy, and (f) a postsplenectomy syndrome. A second major hematologic classification would be primary thrombocytosis, a condition only recently described in children.[3] Third would be the presence of abnormal cryoglobulins. Finally under the embolic category, we would include subacute bacterial endocarditis (SBE) and cardiac mural thrombi.

We can then go on with each symptom, sign, and finding in this case and determine which diagnoses are still compatible. For instance, we could look at the increased gamma globulins and find that these have been reported in polyarteritis, SLE, sarcoid, infections, primary thrombocytosis, and SBE. Or alternatively, we could look at each condition and check its major characteristics to see whether there would be evidence for or against the diagnosis. As an example, Takayasu's syndrome is much more prominent in the upper extremities than in the lower, and yet our case has more symptomatology in the lower extremities than in the upper. So, this would be a point against this condition. As far as atherosclerosis of a diabetic origin is concerned, this is first of all rare in childhood, and there is no evidence presented that the patient had sugar in the urine or elevated blood sugars. There is no particular finding that would suggest this diagnosis specifically. The same can be said for medial calcification.

If we consider Buerger's disease in the same way, we find that it is 75 times more common in males than in females, and when present in females, it is usually a mild disease. Furthermore, half of the persons affected have been of the Jewish group, and the great majority are older adults. The only point for Buerger's disease would be that gangrene has been reported and the course in general is compatible with Buerger's phenomena (although smoking was not a prominent feature of this child's life as far as we know!). A subclassification of Buerger's disease would be ergotism. This could explain the sex in this case since ergotism has been reported primarily in females; but we have no history of accidental or intentional ergot administration.

Raynaud's disease is more common in females, and although gangrene is generally a very rare complication, and ordinarily minimal when it occurs, acute fulminating cases of presumably Raynaud's phenomena have occurred in children. Against this possibility is the absence of generalized symptoms of intermittent and modifiable vascular spasm in the extremities.

We could go through the remaining possibilities in the same way, but it might be more worth while at this time to program our thinking in such a way that we combine both the appearance of certain signs and symptoms with the for and against concept. When we do this and examine polyarteritis, it is impressive that this patient has a number of signs, symptoms, and findings which are compatible with polyarteritis. These include fever, leukocytosis, anemia, and the presence of elevated gamma globulin. Somewhat against the diagnosis of polyarteritis is the absence of pain in the abdomen and the lack of urinary findings which are usually present.

Recently, however, it has been suggested that there may be two forms of polyarteritis—one, generally unassociated with any other major process, but often fatal within about 12 months. The second is more nearly what one might call a hypersensitivity angiitis involving multiple organs with signs, symptoms, and positive laboratory findings. A finding that is permissive for this diagnosis, but not particularly helpful is the fact that gangrene, although rare in polyarteritis, has been reported in a number of cases. Very closely allied with this diagnosis is that of systemic lupus erythematosis and a strong point in its favor is the fact that 85 per cent of the cases occur in young females. Furthermore, pericardial involvement is frequently reported, and increased gamma globulins are also associated with this disease. On the negative side, however, is the fact that LE preparations were repeatedly negative, and gangrene is even more uncommon in this situation than in polyarteritis; when gangrene does occur in SLE, it is usually minimal.

Going on down the list, there is no particularly strong evidence for or against the other conditions until we get to primary thrombocytosis which is a situation in which there are increased platelets and recurrent thromboses with gangrene as well as elevated gamma globulin. Against this diagnosis, however, (except for the fact that this is a clinicopathological conference, which perhaps

our computer should ignore) is the fact that there was only one platelet count, and it is not grossly abnormal. In the reported cases of primary thrombocytosis platelet counts were at least three times the normal value. Furthermore, there has been only one previously reported case in a child.

If we then look back at the information we have obtained, we can do as the computer would normally do under these circumstances and give a percentage likelihood or a rank order relationship for the various diagnoses. I believe that the preponderance of findings would suggest to my mind as well as to a computer that polyarteritis would be the most likely diagnosis. We would have to consider the possibilities of other conditions and we might list SLE second or if the computer had been fed the information that this was a clinicopathological conference and also had been told what such conferences were like, it might elevate the position of primary thrombocytosis to a second spot and put SLE third. Then the computer would probably have placed SBE fourth and in fifth place would fall Raynaud's disease. That would about limit the possibilities which the computer would consider. It also ends the possibilities that I would like to consider.

Clinical Diagnoses
Thromboangiitis of undetermined etiology
Iatrogenic hyperadrenalcorticism

Dr. Weil's Diagnoses
Periarteritis nodosa
R/O systemic lupus erythematosis
Iatrogenic hyperadrenalcorticism

Dr. D. R. Shanklin (Associate Professor of Pathology and Pediatrics):

The autopsy was performed 12 hours after death. The skin was remarkable over the right lower extremity particularly around the ankle; large areas of epidermis could be stripped off easily. Dry gangrene was noted in the distal phalanges of most fingers. The nail and distal phalanx of the left middle finger were present. Ulcerated lesions were noted over the lateral aspects of the nares. Bullous erythematous lesions were noted in the left lower extremity on the anterior surface of the ankle. Bilateral transmetatarsal amputation had been performed. Both operative sites were reasonably well healed.

The heart was nearly twice normal size weighing 175 Gm. and the right heart was under considerable pressure. The smaller epicardial coronary vessels were nodular and thickened. Cross section revealed almost complete occlusion of the lumen. The other striking gross lesions were restricted to the adrenal and the colon. The adrenals together weighed only 4.8 Gm., about half that anticipated, and showed nodular cortical surfaces and an abundance of brownish yellow pigment. An area of dark reddish brown discoloration 4 cm. in diameter was noted in the descending colon. Adjacent lymph nodes were unusually prominent. On sectioning, fibrosis was seen within the left ventricular myocardium and a thrombus was found in one of the major branches of the mesenteric vascular route which, however, was not anatomically close enough to the colonic change to determine precisely whether it was related pathogenetically. The kidneys were swollen and pale, but showed no definitive infarction or thromboembolism. A few small flamelike thrombi were present in the subcortical areas and spotty hemorrhage was seen elsewhere throughout the body.

With the relatively scant gross changes and obvious arterial lesions only in the epicardium, the extent of disease seen microscopically came somewhat as a surprise. Figure 1 shows a typical lesion in a smaller branch of the coronary

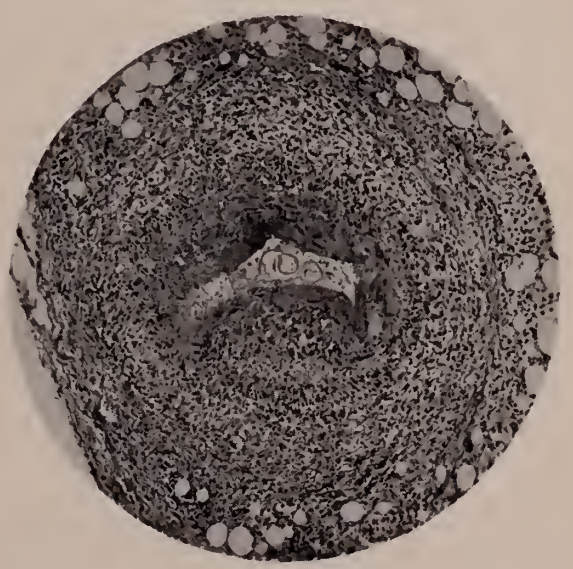


Fig. 1. — Epicardial coronary artery showing extensive fibrinoid degeneration of intima and intermedia with swelling and cellular infiltration throughout the remainder of the vessel thickness. Hematoxylin and eosin. 160 x.

artery system. Advanced fibrinoid necrosis of the inner media and intima is present with an extremely active inflammatory cell infiltration throughout the entire media and adventitia. There are distention, disruption and destruction of all layers of the vessel. This lesion exemplified those which were seen more or less throughout the heart including the superficial epicardial vessels beyond the named branches and within the substance of the heart. Elsewhere thrombosis with some areas of recanalization was seen. In numbers of the pulmonary arteries a hyaline degeneration of the adventitia with thickening was also present. Arterial lesions were seen in the portal areas of the liver. A later or healing phase with hyaline degeneration and adventitial thickening was noted in the spleen. Arterial change was also seen within the substance of the pancreas, adrenals, kidneys, uterus, ovaries, gallbladder, intestine and colon, skin and subcutaneous tissue, and choroid plexus, and in the superficial arteries of the base of the brain.

These lesions were in various stages of progression and particularly in the spleen and lung a healing stage appears to have been reached. In the majority of such lesions a thrombotic process was seen within the lumen. Other anatomic findings of importance to the case included a cellular dissociation in the liver which we see frequently in patients treated with large doses of steroids and the evident atrophy of the adrenal cortex arising from the same mechanism. Ovarian tissue showed extensive depletion with little functional stromal tissue left and rare graafian follicles. It is clear then that from such progression of disease, possibly in connection with the massive steroid therapy, even if the disease were to go into long term remission, the fertility of the patient would be severely compromised if not destroyed.

From the direct and purposeful manner in which Dr. Weil has attacked this case I would doubt very much that he needs a computer to assist him in diagnosis. If we knew what information to program on a computer, however, we would like very much to use this instrument to help us determine etiology and pathogenesis. A specific triggering event such as a virus infection, a surgical operation, or as in this case an episode of physical trauma may bring to obvious clinical light a progressive illness the basic conditions for which pre-exist in the individual patient. What would be of greatest help in a disease state which is so frequently fatal in outcome, is to be able to identify those patients whose vascular systems are particularly predisposed by whatever means to the development of this process or related processes (such as sensitization angiitis) in order appropriately to interfere with the development of definitive lesions.

On the basis of the initial gross examination of the organs it was thought that this patient may have fitted into the group of primary cardiac periarteritis nodosa which has been reported occasionally in relatively young children as an isolated entity.[4] The microscopic studies clearly demonstrate the uniformity and universality of the arterial changes in this case although it must be said that the autopsy study fails totally to reveal the primary basis for either the initiation or the continuing stimulus to the development of the lesions found. Brennemann[5] has summarized the general experience and thinking on polyarteritis nodosa. There is a clinical impression, as yet undocumented, that this condition is more common today. If so, it may relate to the more widespread use of drugs capable of sensitizing the vascular system. Further study is required in the mechanism of pathogenesis and in the role of antigen-antibody and immunosuppressive systems in this interesting lesion.

Anatomical Diagnoses

Periarteritis nodosa, generalized, with lesions in heart, kidney, lung, liver, pancreas, spleen, ovaries, uterus, adrenals, gallbladder, intestine, colon, skin, choroid plexus, subcutaneous tissue, and extracortical cerebral arteries

Gangrene, dry, distal extremities

Polyserous effusions

Status post transmetatarsal amputations

Cushingoid state; adrenal atrophy, cellular dissociation of liver, and ovarian cortical atrophy.

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President's Page

To Keep A Steady State

Under the provisions of Public Law 89-97, Title XVIII B (Supplementary Medical Insurance), a fiscal intermediary or insurance carrier may arrange for compensation of vendors of medical care to the insured. Title XIX authorizes the state agency administering assistance or an insurance carrier to act as the fiscal intermediary for the tax-supported medical program for welfare recipients and the needy. There should be a fiscal *receiver* for compensation available to physicians for services to the needy.

Such a fiscal receiver should be designated by the state medical association and charged with several responsibilities:

1. It should receive all funds payable by the fiscal intermediary for physicians' services rendered to welfare recipients and other needy persons through tax-supported health care programs.
2. From funds received of the fiscal intermediary, it should compensate physicians for services rendered, but reserve that percentage necessary to insure availability of services for the full 12 months and for administrative and educational purposes.
3. At the end of the fiscal year, it should reimburse physicians, as far as practicable from funds remaining, for the percentage withheld from the fees for services rendered.
4. It should deposit into the appropriate nonprofit medical educational fund a portion of the fee as authorized by the physician rendering the service.
5. It should appraise and endeavor to improve the efficiency and effectiveness of the medical services provided.
6. It should consult with the state agency and fiscal intermediary in the development of programs of medical care.

The Florida Medical Foundation, established in 1956, has been used to a limited degree for this purpose but sufficient to establish legal precedent, income tax exemption, and method by which hospital medical staffs, county medical societies, and state medical associations may conveniently use this legal entity for a variety of purposes. A staff or society, simply by letter, may arrange for the Foundation to be the trustee of funds to be released in the manner prescribed by the depositor.

This vehicle will enable physicians to assume fully the responsibility to supervise and insure availability of medical care in hospitals and out by appropriate action of medical staffs and county medical societies. It will provide funds for organizations of physicians to employ personnel for administrative, educational and medical services and it would be the most effective utilization review method.

When Public Law 89-97 becomes operative, the 'status quo' of the medical environment will not be preserved by doing nothing. Indeed, a 'steady state' can be maintained only by vigilant cooperative action of the medical profession. The fiscal intermediary of Title XVIII B and a fiscal receiver for physicians' services provided under Title XIX would be convenient vehicles for physicians' effective cooperative vigilant action.

H. Phillip Hampton



Urinary Calculi

Morphologically urinary concretions are aggregates of crystal and large organic molecules. Calculi large enough to produce clinical symptoms contain several types of crystals and several large organic molecules. In terms of incidence, calcium and phosphate are by far the most common inorganic constituents, appearing in the ash of the organic molecules of all calculi, crystalline hydroxy calcium phosphate (apatite) in 75% of calculi, and as other crystalline forms in an additional 5%. In terms of mass, calcium oxalate is the major component of more than 50% of calculi and magnesium ammonium phosphate is the major component of an additional 25 to 35%. The organic components are quantitatively predominantly mucoprotein in all urinary concretions. If we wished to list characteristics of urinary calculi the most obvious is their extreme variability quantitatively and qualitatively in crystalline composition and quantitatively in mucoprotein content (3 to 85% of dry weight). A second characteristic is the small size of the individual crystals; only calcium oxalate dihydrate crystals are large enough to be seen with the unaided eye and these are never so large that a single crystal produces urinary obstruction. In general, the unit crystals of calculi require the higher powers of light microscopy for identification. Cystine and magnesium ammonium phosphate are among the largest, several hundred microns in longest axis; calcium oxalate monohydrate and uric acid crystals are even smaller. Apatite crystals are 30 by 400 angstroms in size and visible with the electron microscope. Another characteristic of urinary concretions is the universal presence of calcium, phosphate and mucoprotein, albeit finite quantities.

Such complex structures develop by growth and in definition of the total process of development the German term "Harnsteinbildung" seems appropriate. The stone building process may be regarded as the vector sum of (a) crystal nucleation, (b) crystal growth, and (c) crystal bonding. In the genesis of every gross concretion there must have been one single primordial crystal. In the genesis of this crystal there must have been one phase in which it existed as the smallest unit of its crystal lattice. Nucleation is that point at which the crystal lattice becomes stable, that is, the kinetic characteristics of the ions become those of a solid rather than those of a solution. Crystal

See Urological Symposium beginning page 115

growth occurs as additional molecular units (not individual ions) are added to the nucleus. Many crystal exist for a time as microcrystallites, larger than the theoretically smallest lattice unit, and yet by all other criteria they are solutes rather than solids. Crystal nucleation and crystal growth are influenced by different characteristics of the melt (environment). For example, spontaneous nucleation requires much higher concentrations of crystallites than does crystal growth, that is, growth will occur in solutions in which crystallization will not occur. Surface tension is an important factor in nucleation and in microcrystallite formation but of little or no importance in crystal growth. On the other hand, nucleation may be induced in solutions in which it will not spontaneously occur by introducing molecules or substances which capture or concentrate ions, which position ions (epitaxy), or by "seed" crystals. In the proper melt apatite crystals have been induced to nucleate by collagen, saliva extract, elastin, tendon, aorta, rachitic bone cartilage, calciphylactic skin and bacteria.

Crystal bonding, that is, the firm union of crystals, is essential to stone building, else we have individual crystal nucleation and growth that pro-

duces the crystalluria present in some degree in every human every day.

One additional point about stone building is the role of the mucoprotein. Somewhere in the process there must be added the first mucoprotein molecule. Does it precede the primordial crystal? Does it nucleate one crystal type? Does it provide multiple centers of nucleation so spatially related that crystal to crystal bonds occur? Does it form a net or a "brush heap" in which single crystals are entrapped until the whole is filled? There are no irrefutable answers to these questions, but if it serves any one of these purposes then the mucoprotein component is a matrix, that is, a mold, a uterus, or a biologically active mother cell.

In this attempt at simplification we have barely touched on the physical chemistry of electrolytic solutions. These properties, which vary with composition and concentration of the urinary melt, are all important to crystal nucleation and growth. These are the properties which give credence to the concept of "solubilizers" which maintain urinary crystalloids in solution against concentration gradients which are unrealistic for nonelectrolytic solutions.

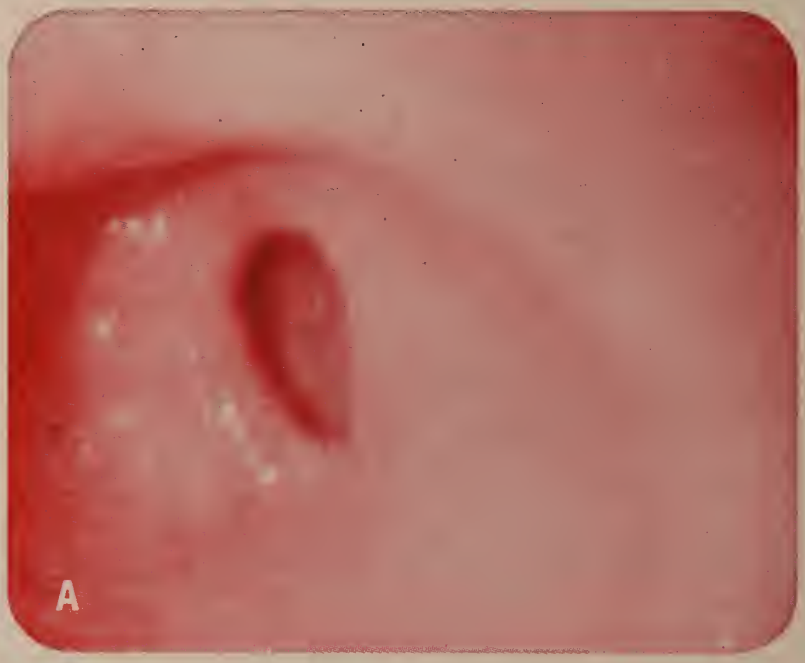
Practically all of our knowledge relative to human stone formation represents clinical observations. Concepts derived from such observations are in the nature of attempts to construct questions to fit the answers. In the field of stone formation the answers are all too often only partial since they are obtained from acutely ill patients at a time when the pathological process is advanced and usually complicated by secondary factors. Under these conditions it is not surprising that each observation (answer) has more than one equally applicable question. For example, magnesium ammonium phosphate calculi appear in the presence of urinary infection with urease producing bacteria. This observation can be related to the question of solubility of magnesium ammonium phosphate in solutions of near pH 8. These same bacteria have many other properties, they invade the renal parenchyma with all the disturbances of renal function which accompany pyelonephritis. They also produce alkaline phosphatase, a high energy source for release of phosphate. The ammonium ions they release are toxic for many enzyme systems. Why do so many patients with comparable pyelonephritis fail to form calculi?

These observations establish the need for a biochemical, physiological, bacteriological and anatomical profile of every patient with urinary calculi. The biochemical survey requires accurate determinations of all potential crystalline components in terms of concentration per unit volume in both blood and urine, and indicators of systemic acidosis. The physiological survey includes an evaluation of renal function and functional reserve, the ability to acidify the urine, to concentrate antimicrobial agents, or susceptibility to potentially nephrotoxic antibiotics. The anatomical survey is a complete urological evaluation; how many calculi, how can they be removed, what obstructions must be corrected, how can infection and inflammation and urinary extravasation and injury be minimized? The bacteriological survey requires a knowledge of all bacteria, the agents to which they are susceptible, and any changes in bacterial flora. Obviously this type of profile offers an excellent opportunity for computer programing.

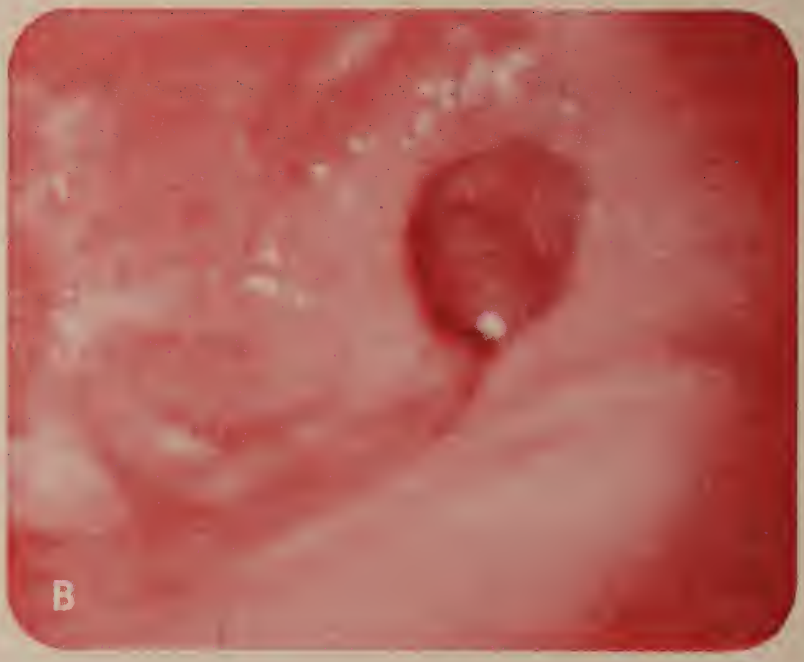
Granted that we have no universal control of crystal nucleation, every patient with urinary calculi can be cured or greatly improved by a total approach to the problem. At least 12% of patients with recurrent or multiple calculi have hyperparathyroidism and are cured by removal of the hyperplastic parathyroid tissue. Combinations of alkalinization of the urine, maximal urine volume and, when necessary, D-penicillamine (Cuprimine) will prevent the formation of cystine calculi. Control of urinary infection may require prolonged hospitalization and truly massive doses of intravenously administered antimicrobial agents, repeated bacteriological studies, and corrective surgery.

Calculi too large to pass through the ureter inevitably represent a loss of renal function by obstruction and infection. They should be removed surgically. The best methods of in vivo dissolution by irrigation are subject to more pain, prolonged hospitalization and greater loss of renal function than is adequate and meticulous surgery. Adequate surgery is not removal of all calculi; it includes the correction of anatomical-confined defects in urine flow, confines the urine to the urinary system, minimizes renal infarction, avoids external drains and postoperative cicatrization. Even the most skillful surgery is frequently inadequate unless the total approach to prevention of recurrence is employed before, during and after the removal of the calculi.

(Continued on page 132)



Which Is Pyloroplasty with Vagotomy?
Which Is Pro-Banthine?



Photographs—Harry Barowsky, M.D., Lawrence Greene, M.D., and Robert Bennett, M.D., from a Scientific Exhibit presented at the Annual Meeting of the American College of Gastroenterology, Bar Harbour, Florida, Oct. 24-27, 1965.

Another example of
Pro-Banthine®
(propantheline bromide)
a true anticholinergic in action



Normal relaxed pyloric antrum; contracted pylorus (pyloric fleurette)

The true anticholinergic values of Pro-Banthine have never been so graphically realized as they are with the recent development of fibergastroscopy and the intragastric camera.

Pro-Banthine consistently produces complete relaxation and immobility of the stomach with a dose of only 6 to 8 mg. intravenously. This is less than half the usual dose orally.

Atropine, on the other hand, required 0.8 mg. intravenously, or twice the normal dose, to achieve a similar effect. This high dose of atropine resulted in expectedly adverse side effects.

Pro-Banthine, in minimal dosage, produces effects similar to pyloroplasty and vagotomy without the disadvantages of permanent post-vagotomy sequelae.

The intragastric photograph A is of a patient who has had pyloroplasty with vagotomy. Photograph B is of a patient given 6 mg. of Pro-Banthine.

Indications: Peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

Oral Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

Side Effects and Contraindications: Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. Pro-Banthine is contraindicated in patients with glaucoma, severe cardiac disease and prostatic hypertrophy.

SEARLE

Research in the Service of Medicine

(Continued from page 129)

Uric acid calculi are prevented by control of gout, alkalinization of the urine, and maximal urine volume.

"Calcium oxalate" calculi occurring in sterile urine are reduced in number and rate of growth by careful attention to the many variations presented by these patients. The addition of phosphate to the diet as recommended by Drs. John E. Howard (Baltimore) and William J. Thomas (Gainesville, Fla.) has been highly effective when properly employed. The dose of phosphate as potassium acid phosphate should be sufficient to maintain the urinary phosphorus at levels of 1,400 mg. or more per day. The patient with systemic acidosis or inability to acidify the urine is given a ratio mixture of monobasic (KH_2PO_4) 381 mg. and dibasic (K_2HPO_4) 119 mg. per capsule. A total dose of 6 to 10 Gm. of these salts per day is the usual dosage (equivalent to approximately 1.4 to 2.2 Gm. of phosphorus as P). Approximately one in five of these patients will have unexplained hypercalcinuria and may benefit from a low calcium, low Vitamin D diet.

In summary, from a purely clinical point of view the group of human patients afflicted with urinary calculi represent no single recognizable disease entity. Rather they are a group of diverse populations with subgroups in each. Success in management requires the coordination of medical and surgical diagnostic and therapeutic modalities over prolonged periods of time.

William H. Boyce, M.D.
Professor and Chief, Section on Urology
Bowman Gray School of Medicine
Winston-Salem, N. C.

Is the Task Hopeless?

"Hôpital Albert Schweitzer" — Dechapelles, Haiti — built by Dr. William Larimer Mellon, was named to honor the spirit and genius of Albert Schweitzer. In a despondent portion of the world less than 750 air miles from Miami, this hospital is a living tribute to the finest traditions of medical practice. I have been there. For five weeks, on the invitation of AMDOC, I have had the privilege of doing general surgery at Dechapelles. The experience in surgery was phenomenal, but the privilege of being associated with Dr. Mellon makes a dwarf of the clinical experience.

William Larimer Mellon Jr. was born in opulence. He felt himself a misfit in a family known principally for its wealth. In 1947 Dr. Mellon became inspired by a reverence for the work and philosophy of Albert Schweitzer. This interest crystallized as an ambition to build a hospital community in an area of the world where the need seemed greatest.

His success in attaining this goal is almost unbelievable. Mellon was 38 years of age when he entered Tulane University School of Medicine. He completed his medical education and opened the hospital in 1956. While still a medical student he traveled the world in search of an ideal location. He chose Dechapelles in the heart of the Artibonite Valley in Haiti. This is a poverty-stricken, overpopulated area plagued by ignorance, malnutrition and disease. The people of this region have no understanding of sanitation and have polluted their streams and water supplies. Their lives are guided by voodoo witchcraft. Agricultural methods are primitive. Pigs and cattle are scrawny and diseased. The need for medical care and education is great.

Hôpital Albert Schweitzer is a modern oasis in this valley of despair. It is beautiful, clean and

well equipped. It is crowded, and perpetually runs over capacity. Though it cannot possibly satisfy the medical need of this vast population, it is hope and a miracle to those who enter.

The hospital is only a part of the project. Larry Mellon is a one man Peace Corps. He has built schools, sponsored crafts, and taught sanitation. He helps the natives grow healthy pigs and chickens. He is a physical part of every program, exemplifying the Mellon philosophy. . . . "When there's a job to be done, the only hand you should count on is the one at the end of your arm."

Mellon is neither preacher nor crusader. He takes no part in politics or controversy. He has made the natives understand that they must improve their way of life and he is showing them how to do it for themselves. The task is gigantic and appears hopeless. "One washes his hands and dries them in the mud" is an old Haitian proverb. The motivation in this project is real and the situation far from hopeless. Mellon does not just lead — he inspires. As William Larimer Mellon was inspired by the work of Albert Schweitzer, so Mellon inspires others in the same manner. This ability has a chain reaction effect which is far greater than the immediate result of any one project.

Men were inspired to form AMDOC, HOPE, and MEDICO. We of the Florida Medical Association are proud of the inspiration, wherever it came from, that launched our Trujillo, Honduras Project.

HENRY M. STERN, M.D.
LAKELAND

The Family Medicine Program of the University of Miami

In recent years much has been written about the dwindling number of physicians available to render primary medical care. There is general agreement that a great need exists for a family physician whose basic concern is the health maintenance of the family and it has been proposed that a new specialty, Family Medicine, be developed. To date, however, no medical school has offered a coordinated program to train physicians at all levels of medical education. The Family Medicine Program at the University of Miami School of Medicine is such an attempt.

The ultimate purpose of the Family Medicine Program is the provision of well trained, competent family physicians for medical practice.

The specific objectives of the Program are:

1. To encourage students, interns and residents at the School of Medicine and Jackson Memorial Hospital to acquire the knowledge and skills needed for the practice of Family Medicine and to develop the attitudes and ideals of the good family physician.
2. To demonstrate to the student physician, the school faculty and the medical community optimal family health care.
3. To develop Family Medicine further as an academic discipline and to define further its body of knowledge.

The Medical School program is an elective course open to students entering their third year. Each student is assigned a family, and serves as its family physician until graduation. This year 19 students applied and seven were selected.

The student physician provides complete family medical care, preventive and curative, to all members of his family under the close supervision of the health team. He offers well child care, periodic health examinations, prenatal and postnatal care, as well as attention during periods of illness. The student doctor or an alternate is accessible to the family on a 24 hour basis. Home visits are made when requested, and he makes daily rounds in the event of hospitalization.

Legal, moral and pedagogical considerations are of paramount importance. The staff physician functions as a preceptor, and he is continually available to the student. He is present at every meeting between the family and the student, and ultimate responsibility for the health of the family resides with this physician.

The second phase began in July of this year. Each rotating intern at Jackson Memorial Hos-

pital is assigned to the program one afternoon a week to care for patients he has selected from his in-patient rotations. The intern is encouraged to look beyond the specific disease process into the total health needs of the patient, and finally extend his attention to the family.

A two year residency in Family Medicine has been authorized within the Department of Medicine of the University to become effective July 1, 1966. Each resident will be assigned a panel of about 50 families, and will serve as their family physician at the Family Health Center. The remainder of his time he will rotate through the in-patient services of medicine and pediatrics. He will also receive instruction in psychiatry, public health and ambulatory surgery. He will be expected to conduct an investigation into some aspect of patient care research.

The clinical facilities are located within the National Children's Cardiac Hospital. The hospital is part of the medical complex that involves Jackson Memorial Hospital and is being developed under the direction of the University of Miami School of Medicine.

The assigned families are seen in the Out-Patient Department (Family Health Center) where laboratory, x-ray and pharmacy facilities are available for use by the Family Medicine Program. The surroundings are pleasant, patients are seen promptly on an appointment basis and parking is ample. The educational and administrative facilities are located in an adjacent building. They include a conference room and library.

The Family Medicine Program presently being developed at the University of Miami is unique in that:

1. It offers integrated pre and post-graduate training in Family Medicine.
2. The training program is based on the health care of well families in an ambulatory setting rather than sick patients in a hospital.
3. Experience in a community health project and research in the area of patient care are an integral part of the program.
4. The program director is a family physician with experience both in active family practice and teaching assignments.

An "open door policy" is in effect at the Family Health Program. Members of the Florida Medical Association are invited to inspect the facilities and to participate in the teaching program.

LYNN P. CARMICHAEL, M.D.
MIAMI

Medical Historians Wanted

Medical history is assuredly one of the fastest moving stories of mankind. To carry out its responsibility to document this ever-changing saga of medical progress, The Journal from time to time publishes articles describing the fascinating history of medicine in the Sunshine State. The most recent such effort took the form of a special historical issue which appeared in July 1965.

Response to the July issue was so overwhelmingly favorable that plans are now being made to publish a sequel sometime during the summer of 1966. The able coordinator of this latest effort is Dr. William M. Straight of Miami, chairman of the Association's Committee on Archives. Dr. Straight set a sterling example to his colleagues by contributing one of the major articles, our readers will recall, for last July's special issue. It was the interesting story of Dade County's first physician, Dr. Richard B. Potter.

An appeal is now being made for all medical authors and potential authors to come forward with the fruits of their historical labors and share in creating the 1966 issue. Even if writing ability may be somewhat lacking, rough materials can easily be smoothed into good form by The Journal's panel of adroit experts with the King's English. Dr. Straight also would be pleased to be advised of any possible untapped sources of medical lore in our fair state. So authors, your aid is needed. Not only will our present good readers benefit, but so will our successors of tomorrow.

T. M.

Association News

Council on Specialty Medicine

Editor's note: The Council on Specialty Medicine requested that each specialty present for publication a short discussion of the reasons for its recognition as a specialty group and the functions of its members. The following articles appear in this series.

T.M.

Urology

A physician, to be considered a bona fide urologic specialist, must devote 100 per cent of his professional time to urology. A minimum of two years in practice is required for him to become an active member of the section of the American Urological Association in the area in which he lives. He must be a member of his section and must be recommended by his section to become an active member of the American Urological Association. This requirement takes at least two more years.

To be certified by the American Board of Urology, the applicant must have received special graduate training as follows: 1. An approved internship of at least one year. 2. One year in the basic sciences or clinical studies basic to urology, or a one year residency in general surgery or internal medicine on an approved service. 3. An approved, graduated, three year residency in urology, leading to competency in all its phases. The applicant to the American Board of Urology also must have an additional period of not less than two years in the practice of urology in the city of his office or place of practice before he is eligible to be examined by the Board. Certification by the American Board of Urology is not a requirement for active membership in the American Urological Association.

The province of urology as a specialty embraces the diagnosis and treatment of diseases of the urinary tract in both sexes (excluding such renal manifestations of systemic disease as glomerulonephritis, and arteriosclerotic nephritis) and of the genital tract of the male. The urologist is a surgical specialist and should be concerned primarily with the surgical diseases of the urinary tract.

It is recognized that a certain overlapping of interest must occur with other specialties, for example: with the gynecologists, particularly in problems of the female bladder and urethra; with the vascular surgeons, particularly in the hypertensive patient with renal vascular problems; with the general surgeon, in hernias associated with problems of the cord or scrotal contents; with the endocrinologist and the general surgeon, in problems of the adrenals; with the general surgeon, in urinary diversionary procedures involving the bowel; and with others. By the same token, it is recognized that the fact that a given disease may manifest itself by lesions in, on, or around the urinary or genital tract does not necessarily put it within the urologist's province. For example, psoriasis of the skin of the penis still is a dermatologic problem.

It is thought that several factors, such as the training and experience of the individual urologist and the availability of specialists in other fields in his community, must influence to some extent the latitude of his practice. We as urologists certainly should appreciate the position of specialists in allied fields and emphasize cooperation with them and mutual respect to the end that our patients will receive the very best care that it is possible for us all to provide.

David W. Goddard, M.D.
Daytona Beach

Pediatrics

Pediatrics is general medical practice in a particular age group. All pediatricians are in agreement as to the lower limit of this age group, which is the time of birth, but there is variation in where the upper limit is placed. Ideally this limit would be the completion of adolescence.

Much of pediatric practice is spent in supervision of the health of normal children. This includes periodic examinations, counseling of parents, and immunization programs. Since the pediatric age group embraces the period of growth and maturation of the individual, the pediatrician must have a broad knowledge of the field of growth and development. The infant and the child are not small adults. They are individuals in whom maturation and growth are occurring at varying rates. For this reason the medical problems of pediatrics are vastly different from those of adult medicine.

In order to be eligible for board certification in pediatrics the physician must have completed one year of internship, which may be rotating or straight pediatrics, plus at least two years of residency training. In addition he must have been in practice for a period of two years. Examination for board certification consists of two examinations, one written, the other oral. The latter examination is given by a group of four examiners, usually pediatricians who hold academic appointments.

One of the interesting present trends in pediatrics, and one which will probably increase, is the development of subspecialization within the specialty. At present this is most prevalent in the university hospitals. Here one finds the pediatric hematologist, endocrinologist, radiologist, cardiologist, and others.

In community practice subspecialization is occurring also. In this setting the pediatrician interested in a special area such as neurology develops this interest while continuing to engage in general pediatric practice. He becomes a consultant for his fellow pediatricians. This would seem to be a healthy development and one which should be encouraged during residency training.

J. K. David Jr., M.D.
Jacksonville

Others Are Saying



University of Miami School of Medicine Loans and Scholarships

JOHN C. FINERTY, Ph.D.*

The old cry of the medical student in dire financial straits is probably just as fervent today as it was when you went to school. There actually is more money available to the student today, primarily from the Federal government, but the situation is still basically the same.

Increasing costs of tuition, books and equipment resulting from more sophisticated medical knowledge and the better standards of living to which today's students are accustomed account for the major reason there is still a pressing need for more loans and scholarships.

This situation exists not only here for our Loans and Scholarship Committee to solve but is a problem common to the 85 other medical schools across the nation.

Many students today who really cannot afford to attend medical school are coming because of the potential availability of loans. This is partially because of wide-spread publicity about long-term, low-interest, Federal loan programs, which has led parents and relatives to encourage students to "let the medical school support them."

A fundamental change in the past 20 years is that many students no longer defer marriage and the beginning of a family until completion of their medical education. An automobile and an adequate home for a family are no longer considered luxuries, but are basic necessities. These factors are primarily a result of an overall change in our culture and standard of living, extension of the period of education and different attitude toward combining marriage and education. Whereas it used to be exceptional for a medical student to be married and to have children, the married students of today are in the majority. In our Class of 1965, consisting of 73 graduates, 41 are married and there was a total of 35 children.

With a working wife, some help from parents and good health, prospects usually look promising to a first year student or an eager applicant for medical school. However, constantly recurring items in loan applications are illness, death of parents and particularly pregnancy, all of which were unanticipated when original plans were made to enter medical school.

Thus far, we believe that we have not lost any students for lack of money directly, but some may have failed academically because of financial worry, too much outside work and the like.

Considering the age of our School, fourteen years, our loan funds have been quite substantial. Principal funds directly controlled by the School total $122,341.56. However, all except $3,433.10 was on loan as of February 9, 1965. Currently, 54 students still owe balances on their 1964-1965 tuition in the amount of $20,217.94.

In September, 1964, before the start of school, our Loans and Scholarship Committee had 122 applications for bona fide loans to consider, totalling $202,800. We received only $75,000 from the Health Professions Loan Fund to lend and had about $20,000 in local funds. So, it was a "strapped" year for our young men and women.

The private medical schools have great need for scholarships as a means of equalizing tuition inequities with state schools. In Florida, as in other states, a student accepted by the state university medical school is automatically the recipient of a scholarship of $600.00 per year since the tuition is that much less.

*Formerly Associate Dean and chairman of the Loans and Scholarship Committee, University of Miami School of Medicine. Now Dean, Louisiana State University School of Medicine.

Within the next few years, it will be a necessity for the UM School of Medicine, indeed, it is a necessity now, to increase not only its loan funds, but most certainly, its scholarships and non-refundable grants. You can be sure that each loan, such as the DCMA's own generous Student Loan Fund, and every scholarship is carefully considered by our Committee before it is awarded. We try to be sure that the money goes where it is most needed. Beginning this year, all applicants for loans among the incoming first year students are required to submit a detailed summary of family resources to an independent agency (College Scholarship Service, Princeton, New Jersey) so that we may obtain an unbiased estimate of actual need.

Our Committee also tries to make certain that any one student does not accumulate such a debt that he must cut short his specialization training in order to begin paying off his debts, or enter into private practice with a staggering loan debt from school days.

It is interesting to note that in a survey made in 1963-1964 by the U.S. Public Health Service and the Association of American Medical Colleges that only 17% of all medical students enrolled in 1962-1963 received non-refundable grants at an average of $585 per recipient.

In contrast, 68% of all arts and sciences graduate students received an average of $2,450 in non-refundable aid and 81% of the life science graduate students received an average of $2,700 in aid.

If interested and capable students, especially those from the middle and lower income groups, are to be attracted to medical studies rather than to graduate work in the sciences; if we are to insure at least our present standard of high quality medical care, it is imperative to increase these non-refundable grants now. The source of such funds is primarily 1) private foundations, medical school budgets, memorials and industry, 2) the Federal government, 3) American Medical Association Education and Research Foundation, 4) regional and local sources such as state or county medical societies and regional foundations, and 5) national foundations.

A new booklet, "Financing a Medical Education," published by the Association of American Medical Colleges, explores this problem in greater depth, and is available from them.

Reprinted from the August 1965 Dade County Medical Association Bulletin.

Guild of Prescription Opticians Policy Statement

Because of the widespread interest generated by Bill Number 2568 which would prohibit physicians from profiting off the sale of prescribed drugs or devices, and because of misunderstandings over the position of their organization, the Guild of Prescription Opticians of America requests that the following policy statement be brought to the attention of the members of the Florida Medical Association:

Whereas, misunderstandings have arisen in connection with the recent Senate hearings on the position of the Guild of Prescription Opticians of America, Inc. regarding the dispensing of eyeglasses by physicians, and

Whereas, there have been attempts to damage the historic close relationship between ophthalmologists and Guild opticians by misrepresentation of its statement on this issue, and

Whereas, the Guild's record is unmistakably clear in its support of medical eyecare as being in the best interest of the public,

Now therefore, the Board of Directors of the Guild of Prescription Opticians of America, Inc. adopts the following restatement of its policy:

We believe that organized medicine at the national and local level should exercise control over any and all practices by individual physicians which bring discredit to the profession. We will support every action which would make federal legislation unnecessary.

We recognize that it is in the patient's best interest if an ophthalmologist dispense eyeglasses in a community where adequate independent optical services are not available or cannot be procured and have so stated in our testimony before the Senate Antitrust and Monopoly Subcommittee.

We repeat our pledge to encourage skilled opticians to provide independent optical services in these communities if requested by an eye physician.

We believe it is in the best interest of the public and ophthalmology if licensing of opticians were obtained in all states and we solicit the active help of ophthalmology and all medicine in securing such laws.

To make these goals attainable, we believe better lines of communication should be established between medicine and opticianry in order to pursue matters of common interest and concern in an atmosphere of mutual respect. We stand ready to work with any individuals or groups who may be interested in making this possible.

It is directed that this statement, which conforms to our testimony before the Senate Antitrust and Monopoly Subcommittee on August 5, 1965, be submitted to that Committee and all interested medical organizations.

Adopted November 14, 1965 at Chicago, Illinois.

News

HEADQUARTERS
3d Motor Transport Battalion (Rein)
3d Marine Division (Rein), FMF
FPO San Francisco 96601

CRN/jbg
28 November 1965

From: Commanding Officer

To: Medical Society, Orange County, Orlando, Florida

Subj: Professional visits of Doctors Joseph E. O'Malley and William D. Simpson to the Republic of Viet Nam

1. The Officers and men of the Third Marine Division and especially the Third Motor Transport Battalion wish to express their appreciation to Doctors O'Malley and Simpson for the work they performed while in the Republic of Viet Nam.

2. During a portion of October and most of November these two doctors, at their own expense, came to Viet Nam under program CARE to perform operations dealing with plastic surgery. They worked day and night and the results of their accomplishments were outstanding. Their over-all accomplishments included 35 cleft lips and palates, one facial flap, one immobilized arm, four napalm burns, one eye removal and dozens of minor treatments. The medical corpsmen of this battalion were able to locate and bring to these doctors six cleft lips and palates, one facial flap, one immobilized arm and one 14 year old girl with a bullet wound in the left femur. The girl, adopted by our corpsmen, was treated on several occasions by the good doctors during their short tenure.

3. More than fifty per cent of our struggle here in Viet Nam is to show the South Vietnamese people that we desire to help them to rebuild a nation, to train professional personnel and to strengthen the democracy of its people. It is only through highly trained professional personnel such as Doctors O'Malley and Simpson that we can accomplish this portion of our mission. It is sincerely hoped that many more such professionals in many walks of our American life will give freely of their own time to assist in our mission here.

4. The morale of our military personnel is raised tremendously by their observation of personnel such as these doctors coming here and giving their all to our cause and a cause which may well result in protection of our American way of life for many years to come.

5. Again we wish to thank and commend Doctors Joseph E. O'Malley and William D. Simpson for their outstanding accomplishments during their stay here and it was indeed an honor for this battalion to assist them and make their visit successful. We ask that copies of this letter be forwarded to appropriate medical journals and to the American Medical Association so that they too can publicize our thanks to members of your profession for aiding our cause. Perhaps also in this way more professionals will be inspired to join the ranks of these doctors in coming to Viet Nam.

F. J. Baker



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References: 1. Kramer, P., and Ingelfinger, F.J.: Med. Clin. N. Amer., *32*:1227, 1948. 2. Hock, C.W.: Clin. Med., *8*:1932, 1961. 3. Winfield, I.W.: Am. J. Gastroent., *31*:438, 1959.

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Deaths

Cole, Herschel George, Tampa; born in Anderson, Ind., Sept. 25, 1898; Indiana University School of Medicine, Indianapolis, Ind., 1925; served an internship and a residency at City Hospital, Indianapolis; later engaged in graduate study at Columbia University Post-Graduate School, New York City, and Cook County Post-Graduate School, Chicago; for 12 years practiced in Hammond, Ind., before locating in Tampa, where he practiced orthopedics for more than a quarter of a century; was a veteran of World War II, serving from June 1942 to January 1946 in the Army Medical Corps, attained the rank of major and was assigned to the post of Chief of Orthopedics in an Army General Hospital in the European Theatre; was for several years secretary-treasurer of the Hillsborough County Medical Association and a representative of that society in the House of Delegates of the Florida Medical Association; was chairman of the Council in 1956 and from 1955 to 1960 was an Associate Editor of The Journal of the Florida Medical Association; was a past president of the Florida Orthopedic Society and of the Railway and Traumatic Surgeons; held membership in the American College of Surgeons, International College of Surgeons, American Medical Association and Florida Orthopedic Society; died Nov. 14, 1965, aged 67.

Crews, Robert Lee, Coral Gables; born in Tulsa, Okla., June 6, 1928; Vanderbilt University School of Medicine, Nashville, Tenn., 1954; interned at University of California Hospital, San Francisco, and served a residency at Jackson Memorial Hospital, Miami; upon completing a two year tour of duty at the 5640th USAF Hospital, Anchorage, Alaska, entered the private practice of obstetrics and gynecology in Coral Gables in 1960; was a member of the American Medical Association and the American College of Obstetrics and Gynecology; died Nov. 10, 1965, aged 37.

Guerin, Briant Bowman, Vero Beach; born in Mendham, N.J., March 24, 1914; Duke University School of Medicine, Durham, N. C., 1941; interned at Detroit Receiving Hospital and served a surgical residency there; served a four year fellowship in surgery at Mayo Clinic, Rochester, Minn., practiced general surgery at Fort Bragg, Calif., for four years and at Sumter, S. C., for one year before coming to Vero Beach in 1952; was a veteran of World War II, serving in the Army Medical Corps with the rank of first lieutenant; was a past president of the Indian River County Medical Society and had served as chief of staff and chief of surgery at Indian River Memorial Hospital; was a member of the American Medical Association, Southeastern Surgical Congress and American Society of Abdominal Surgeons and was a fellow of the American College of Surgeons; died Oct. 26, 1965, aged 51.

Isberg, Emil Mark, Miami Beach; born in Detroit, Mich., Sept. 11, 1914; University of Michigan Medical School, 1938; interned at the University of Michigan Hospital and served a residency in internal medicine there; practiced internal medicine and cardiology in Miami Beach from 1940 to 1949; spent four years in specialty training in psychiatry at the Neuropsychiatric Institute of the University of Michigan Medical Center; had practiced psychiatry since 1954 in Miami Beach; was at one time Associate Professor of Psychiatry at the University of Miami School of Medicine; was a fellow of the American College of Physicians and of the American Psychiatric Association and a member of the American Medical Association, Southern Medical Association, American Federation for Clinical Research and American Psychosomatic Society; died suddenly of myocardial infarction, September 19, 1965, aged 51.

Thomas, Robert Yates Hayne, Jacksonville; born in Jacksonville, 1907; Temple University School of Medicine, Philadelphia, 1935; served a two year rotating internship and a one year residency in surgery at Abington Memorial Hospital, Abington, Pa.; entered the practice of general medicine and surgery in 1938 with his father, the late Dr. Robert Y. H. Thomas II, also a Jacksonville surgeon; was a veteran of World War II, serving in the U.S. Naval Reserve from 1942 to 1944; re-entered private practice in Jacksonville, specializing in industrial surgery; was the first full time medical examiner for Duval County; held membership in the American Medical Association and American Academy of General Practice; died Sept. 16, 1965 after a brief illness, aged 57.

Books Received

A Synopsis of Contemporary Psychiatry. By George A. Ulett, B.A., M.S., M.D., Ph.D., and D. Wells Goodrich, M.D. Ed. 3. Pp. 299. Price $6.75. St. Louis, The C. V. Mosby Company, 1965.

Trauma of the Liver. By Gordan F. Madding, M.D., M.S. (Surgery), F.A.C.S., and Paul A. Kennedy, M.D., F.A.C.S. Pp. 134. Illustrated. Price $6.00. Volume III in the Series Major Problems in Clinical Surgery. J. Englebert Dunphy, M.D., Consulting Editor. Philadelphia, W. B. Saunders Company, 1965.

Diuretic Therapy. An Appraisal of Diuretic Drugs. Edited by Arthur C. De Graff, M.D., and Alan F. Lyon, M.D. Pp. 41. Price $3.50. St. Louis, The C. V. Mosby Company, 1965.

Treatment of the Aging Skin and Dermal Defects. By Perry A. Sperber, M.D. Pp. 105. Illustrated. Price $5.75. Springfield, Ill., Charles C. Thomas, Publisher, 1965.

Principles of Chest Roentgenology; A Programed Text. By Benjamin Felson, M.D., Aaron S. Weinstein, M.D., and Harold B. Spitz, M.D. Pp. 221. Illustrated. Price $6.00. Philadelphia, W. B. Saunders Company, 1965.

Diseases of the Newborn. By Alexander J. Schaffer, M.D. With a section on Neonatal Cardiology by Milton Markowitz, M.D., and a section on Fluid & Electrolyte Therapy by Lawrence Finberg, M.D. Ed. 2. Pp. 1023. Illustrated. Price $22.00. Philadelphia, W. B. Saunders Company, 1965.

Management of the Patient with Cancer. Edited by Thomas F. Nealon, Jr., M.D. With contributions by Seventy-one authorities. Pp. 1067. Illustrated. Price $27.50. Philadelphia, W. B. Saunders Company, 1965.

Rypins' Medical Licensure Examinations. Topical Summaries and Questions. Edited by Arthur W. Wright, M.D. Ed. 10. Pp. 840. Price $12.50. Philadelphia, J. B. Lippincott Company, 1965.

Bone Tumors. By Louis Lichtenstein, M.D. Ed. 3. Pp. 411. Illus. 251. Price $16.75. St. Louis, The C. V. Mosby Company, 1965.

Pediatric Electrocardiography. Normal and Abnormal Patterns, Incorpora ing the Vector Approach. By Warren G. Guntheroth, M.D. Pp. 150. Illustrated. Price $7.00. Philadelphia, W. B. Saunders Company, 1965.

Neurological Surgery of Trauma. Prepared and published under the direction of Lieutenant General Leonard D. Heaton, The Surgeon General, United States Army. Editor in Chief, Colonel John Boyd Coates, Jr., MC, USA. Editor, Arnold M. Meirowsky, M.D. Pp. 604. Illustrated. Price $6.25. Office of the Surgeon General, Department of the Army, Washington, D.C., 1965. For sale by the Superintendent of Documents, U.S. Government Printing Office.

Current Concepts in Medical Practice. John E. Mullins, M.D., Editor. Pp. 436. Illustrated. Price $10.75. St. Louis, The C. V. Mosby Company, 1965.

Management of Juvenile Diabetes Mellitus. By Howard S. Traisman, M.D., and Alvah L. Newcomb, M.D. Pp. 147. Illustrated. Price $12.75. St. Louis, The C. V. Mosby Company, 1965.

Anatomy and Surgical Technique of Groin Dissection. By John S. Spratt Jr., M.D., F.A.C.S., William Shieber, M.D., F.A.C.S., and Burl Mayes Dillard, M.D. Pp. 97. Illustrated. St. Louis, The C. V. Mosby Company, 1965.



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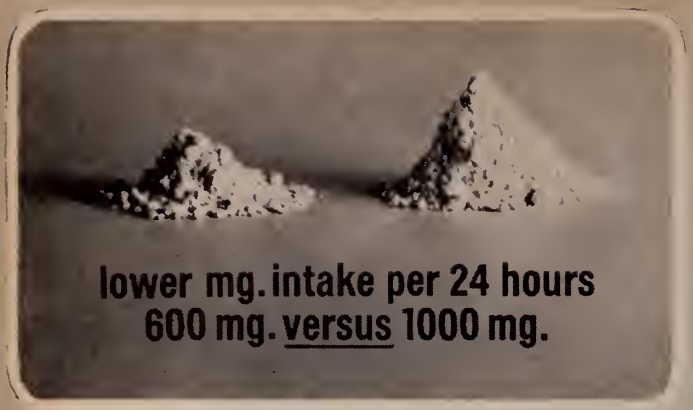
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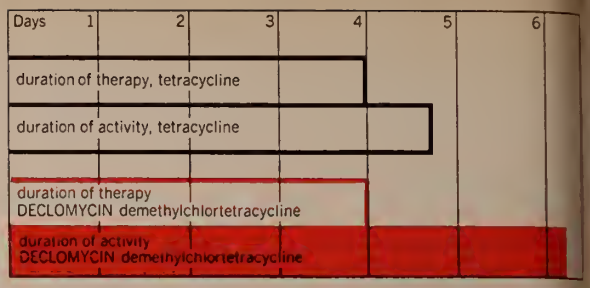
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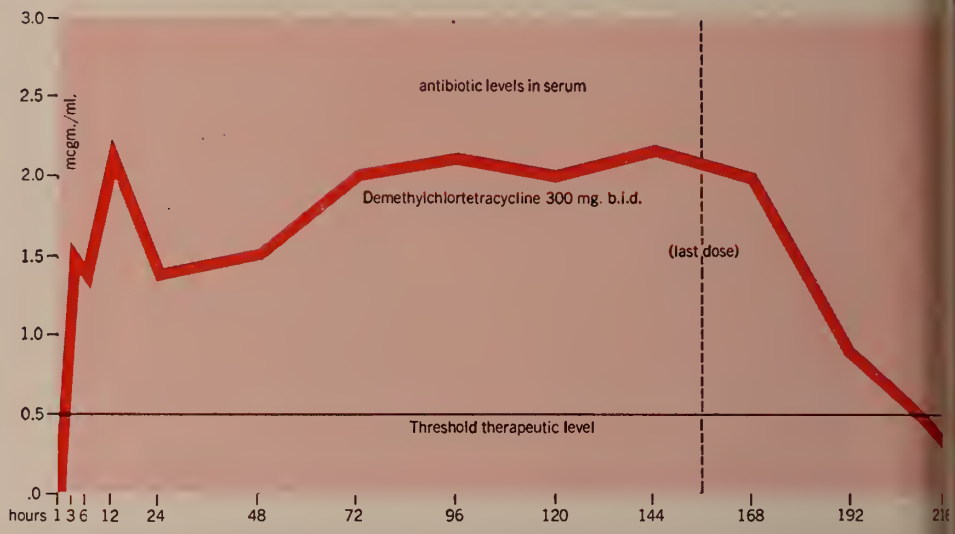


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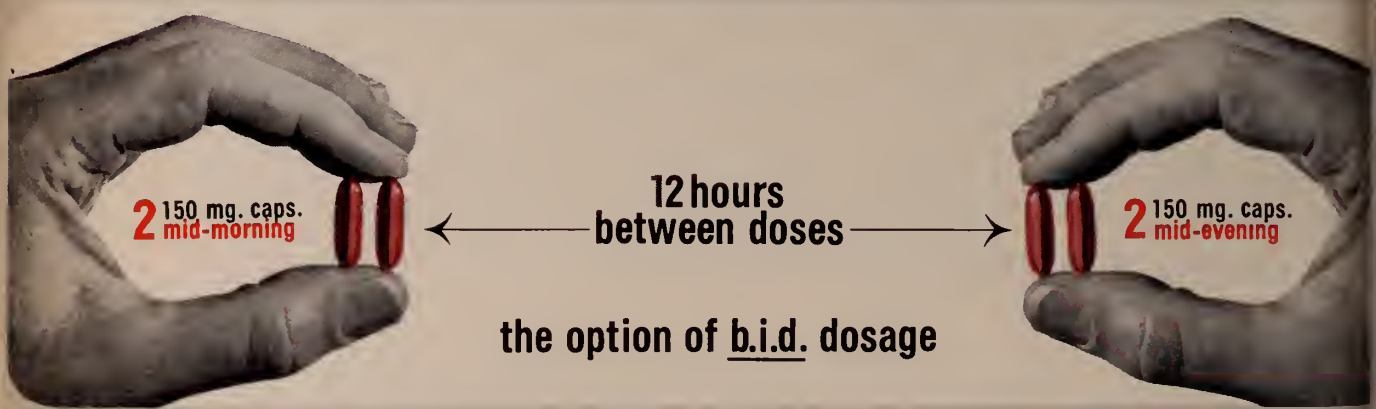


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CD-6405

FOR THE



COMPLEX

TRY DEPROL®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

a logical first choice

FOR DEPRESSION

even when complicated by anxiety, tension, insomnia, agitation or rumination.

- **Acts rapidly.**
- **Side effects at recommended dosage infrequent, usually easily controlled.**

When uncontrolled diarrhea brings a call for help



When the diarrhea sufferer has run
gamut of home remedies without succ
pleasant-tasting CREMOMYCIN can ans
the call for help. It can be counted o
consolidate fluid stools, soothe intest
inflammation, inhibit enteric pathoge
and detoxify putrefactive materials—u
ally within a few hours.

CREMOMYCIN combines the bacteriost
agents, succinylsulfathiazole and neo
cin, with the adsorbent and protective
mulcents, kaolin and pectin, for comp
hensive control of diarrhea.

Indications: Diarrhea. *Contraindications:* Ka
Withhold if diverticulosis is present or suspe
Precautions: Sulfonamide: Continued use req
supplementary administration of thiamine and

your ℞ for Cremomycin can provide relief



K. Neomycin: Patient should be observed for infections due to bacteria or fungi. *Side Effects:* onamide: Sensitivity reactions may occur (e.g., rashes, anemia, polyneuritis, fever; agranulosis with a fatal outcome has been reported). uction of thiamine output in the feces and of min K synthesis has been observed. Neomycin: sea, loose stools possible.

ore prescribing or administering, read product ular with package or available on request.

omptly relieves diarrheal distress

Cremomycin®

NTIDIARRHEAL

mposition: Each 30 cc. contains neomycin sulfate 0 mg. (equivalent to 210 mg. of neomycin base), ccinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0 ., pectin 0.27 Gm.

MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

ere today's theory is tomorrow's therapy

when treatment might precipitate a problem with monilia

especially in diabetics or debilitated patients

and in diabetics — patients with a history of fungal ove growth — patients on steroids who require antibiotics. Tl antimonilial specificity of Nystatin plus the extra benefits of DECLOMYCI Demethylchlortetracycline allow lower mg intake per dose per day, the o tion of b.i.d. dosage, higher activity levels, 1-2 days' "extra" activity.

Side Effects typical of tetracyclines include glossitis, stomatitis, proctit nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible o ganisms, tooth discoloration (if given during tooth formation) and increas intracranial pressure (in young infants). Also, very rarely, anaphylacto reaction. Reduce dosage in impaired renal function. Because of reactions artificial or natural sunlight (even from short exposure and at low dosag patient should be warned to avoid direct exposure. Stop drug immediately the first sign of adverse reaction. It should not be taken with high calciu drugs or food; and should not be taken less than one hour before, or tv hours after meals.

Average Adult Daily Dosage: four divided doses of 1 capsule each or tv divided doses of 2 capsules.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
6585-1998



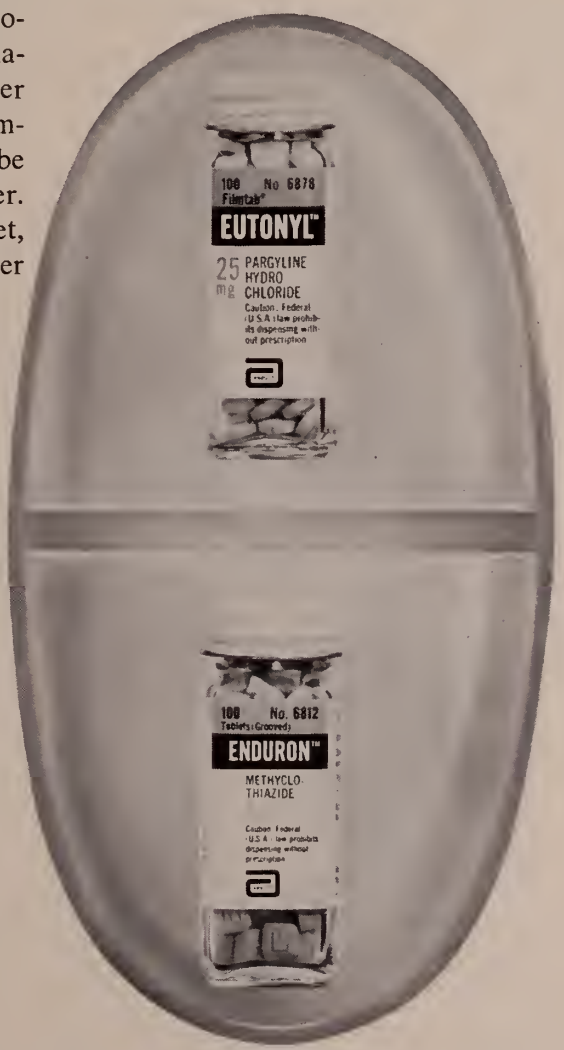
Announcing
EUTRON™

pargyline hydrochloride 25 mg. and methyclothiazide 5 mg.

for control of moderate to severe hypertension

Unique combination produces greater antihypertensive effect with lower doses

Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.



Each Eutron tablet contains two proven antihypertensives in the ratio shown to be most effective in most patients.

TM—TRADEMARK

New **EUTRON** extends your range of treatment in moderate to severe hypertension



A single product you can use even in the presence of congestive heart failure or edema

Eight out of 10 patients respond

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

512214

1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.



BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week — maximum reduction in seven to ten days.



Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for **EUTRON**

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

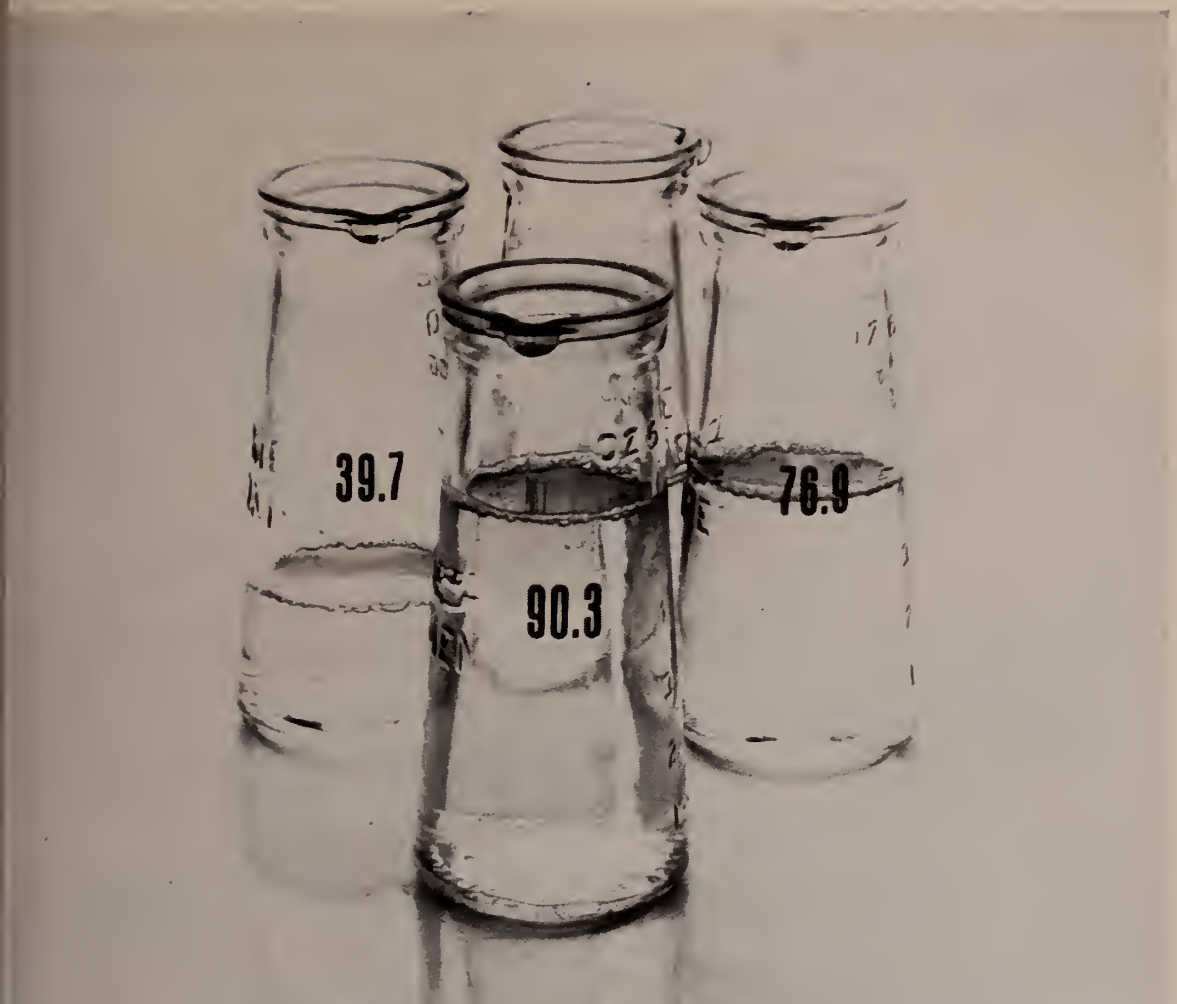
PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

ABBOTT

512214



approximating the diuretic efficacy of meralluride

METAHYDRIN®

(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

the price of "success"



Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

THERAPY
YOU CAN STAY
WITH

METATENSIN®

EACH SCORED TABLET CONTAINS:
Metahydrin® (trichlormethiazide) 2 mg. or 4 mg. Reserpine 0.1 mg.

In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

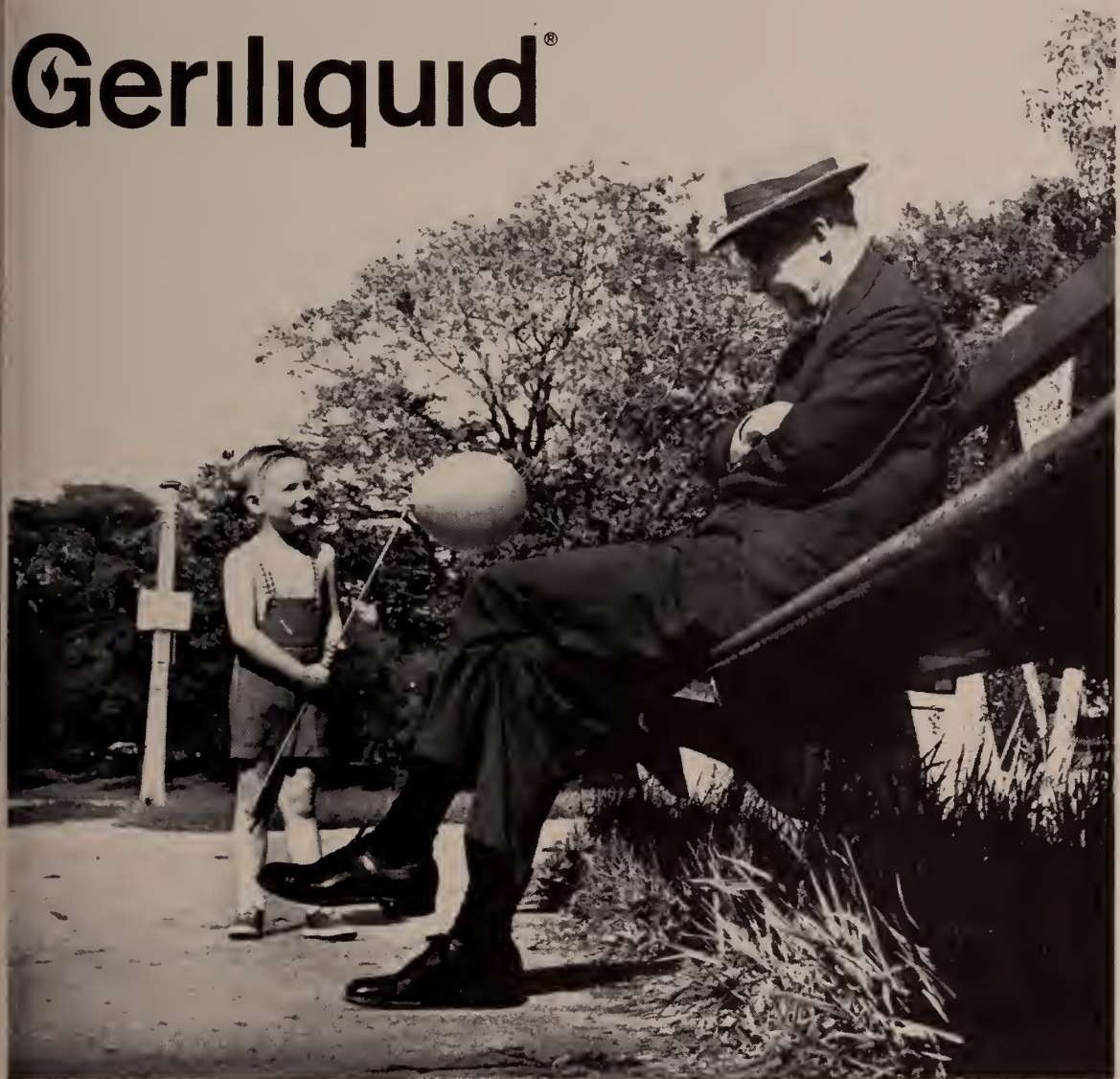
LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

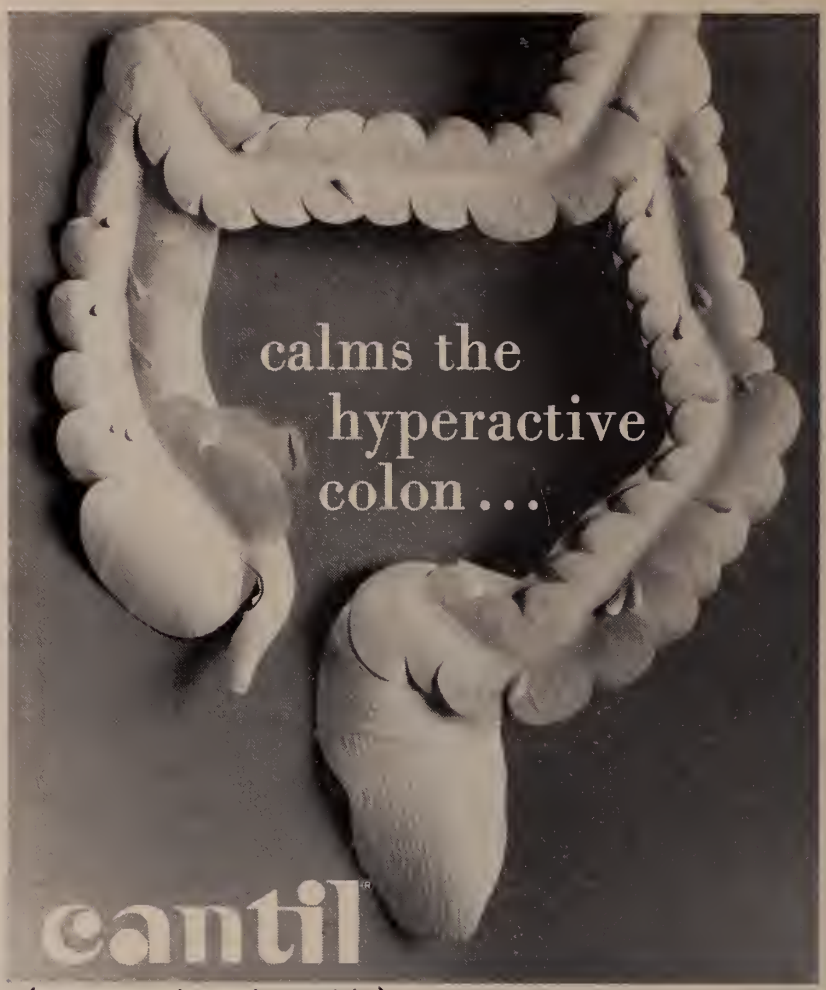
GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

Geriliquid®



IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.
Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.
Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.
Supplied: Bottles of 8 oz. and 16 oz.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201



(mepenzolate bromide)

helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201



more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201


When
tetracycline
is indicated in
these candidat
for Candida...
2.
1.
4.

New low-cost tetracycline/ antifungal therapy

Tetrex®-F

tetracycline phosphate complex –nystatin

Because new Tetrex-F (tetracycline phosphate complex-nystatin) is the most economical therapy of its kind that you can prescribe, it is a sound choice whenever tetracycline therapy is indicated in patients predisposed to monilial infections.

Who are these "candidates for Candida"?

1. diabetic patients
2. nonpregnant women with a history of recent or recurrent monilial vaginitis
3. elderly or debilitated patients
4. patients with a past history of moniliasis
5. patients on long-term tetracycline or corticosteroid therapy.

For these patients, Tetrex-F (tetracycline phosphate complex-nystatin) provides efficient tetracycline therapy against a broad range of infections *plus* protection against superinfection associated with the overgrowth of *C. albicans* in the G.I. tract.

Priced for savings

Tetrex-F (tetracycline phosphate complex-nystatin) is lowest in cost—priced 20% lower than most tetracycline/antifungal products.

BRISTOL THERAPEUTIC SUMMARY

For complete information consult Official Package Circular.

Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.

Contraindications: The drug is contraindicated in patients hypersensitive to its components.

Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. No cases of photosensitivity have been reported with Tetrex (tetracycline phosphate complex). With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).

Precautions: Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.

Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.

Usual Adult Dosage: 1 capsule q.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals.

Supply: Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. Oral Suspension, 60-ml. bottle. Each 5 ml. contains tetracycline equivalent to 125 mg. tetracycline hydrochloride and nystatin, 125,000 units.

BRISTOL

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Syracuse, New York

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WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imleron (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imteron (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imteron (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imleron (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imleron (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imleron (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

in iron deficiency anemia for rapid and predictable replacement of iron reserves

imferon®

(iron dextran injection)



LAKESIDE LABORATORIES, INC. • Milwaukee, Wisconsin 53201



The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say **things go better with Coke**

TRADE-MARK ®

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ASHEVILLE Established 1916 NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

Wm. Ray Griffin Jr., M.D.
Robert A. Griffin, M.D.

Mark A. Griffin Sr., M.D.
Mark A. Griffin Jr., M.D.

a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

often relieves mental pain in 2-5 days

NORPRAMIN®
(desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

Founded in 1904

HIGHLAND HOSPITAL, INC.

ASHEVILLE, NORTH CAROLINA
Affiliated with Duke University





A non-profit, psychiatric institution, offering therapeutic milieu, group and individual psychotherapy, and standard somatic treatments. Limited day-patient and out-patient services. The hospital is located in a 75-acre park amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

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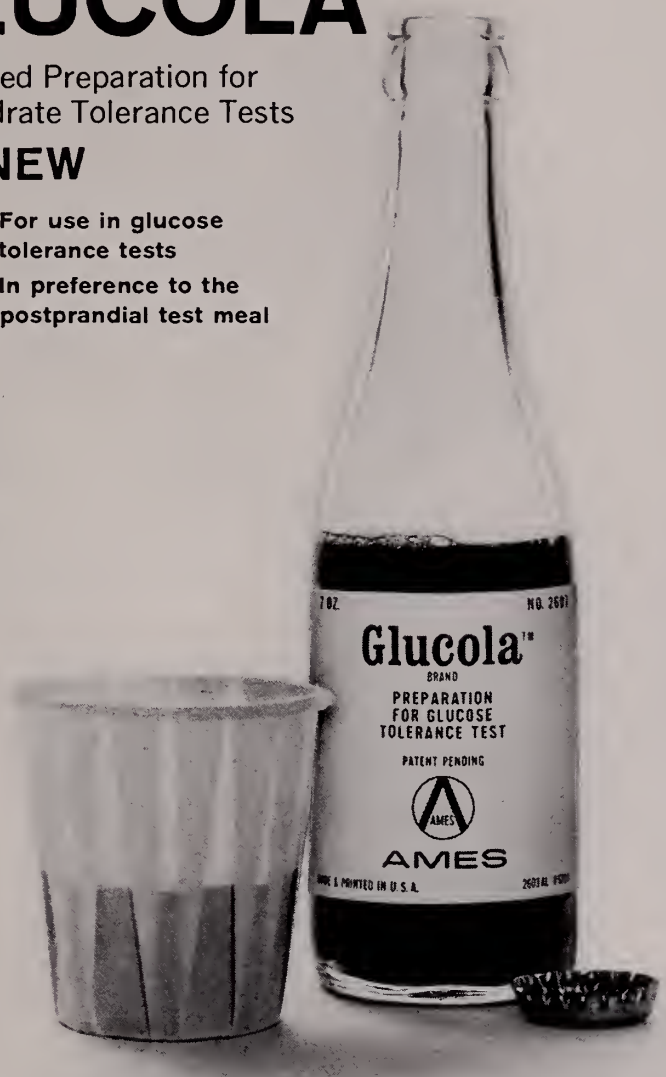
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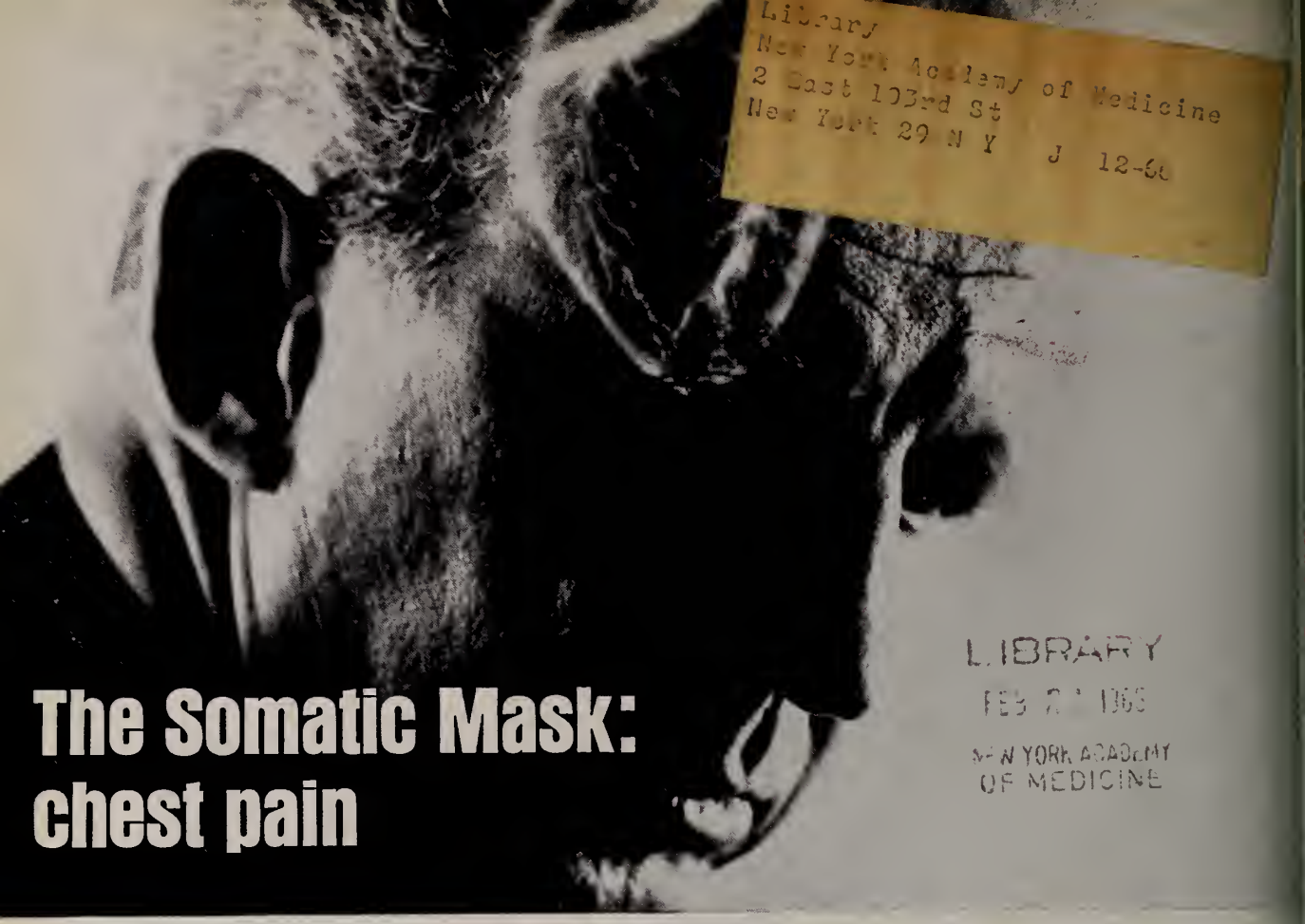
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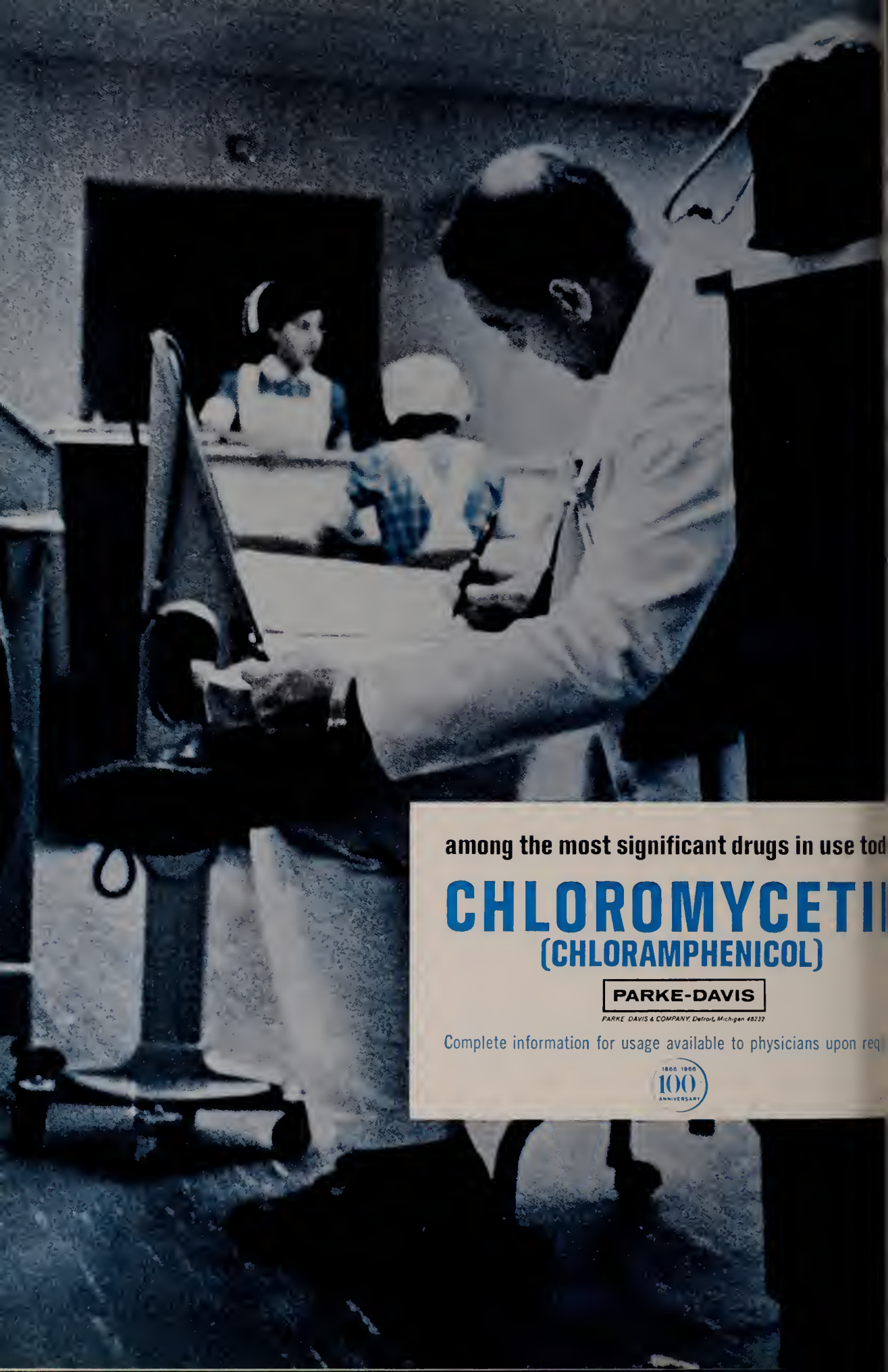
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Intestinal Parasites
Alcohol Withdrawal
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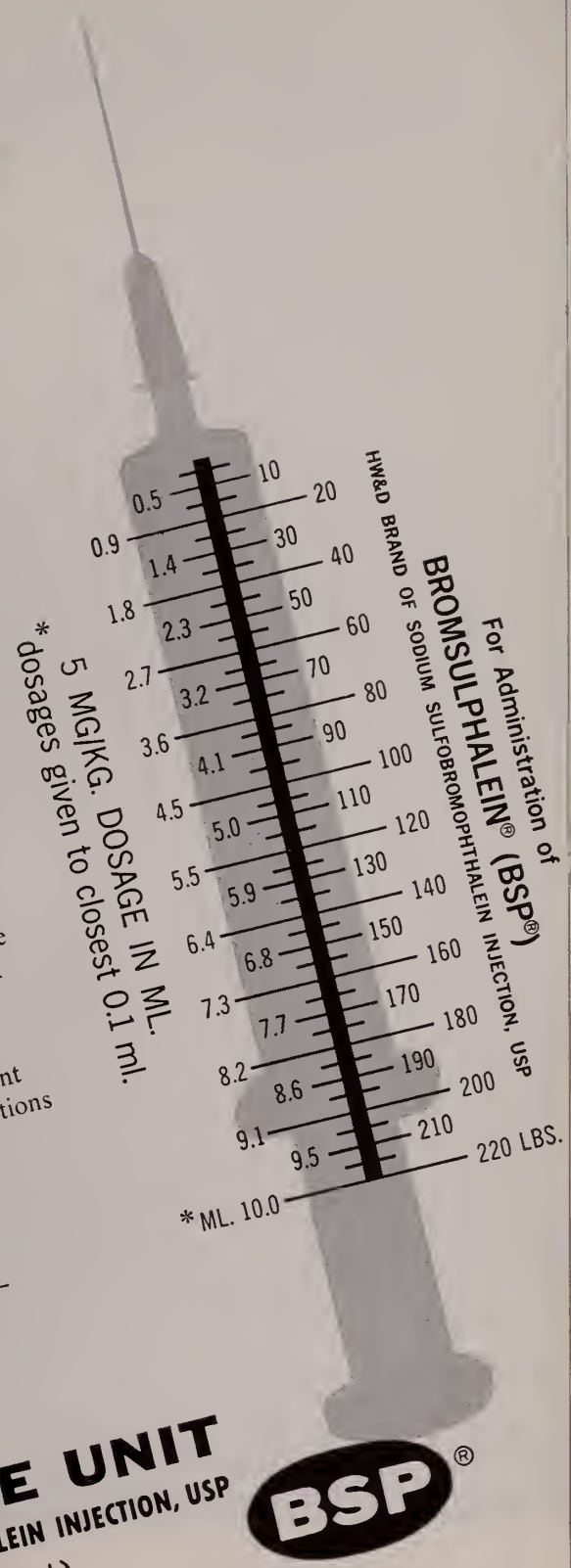
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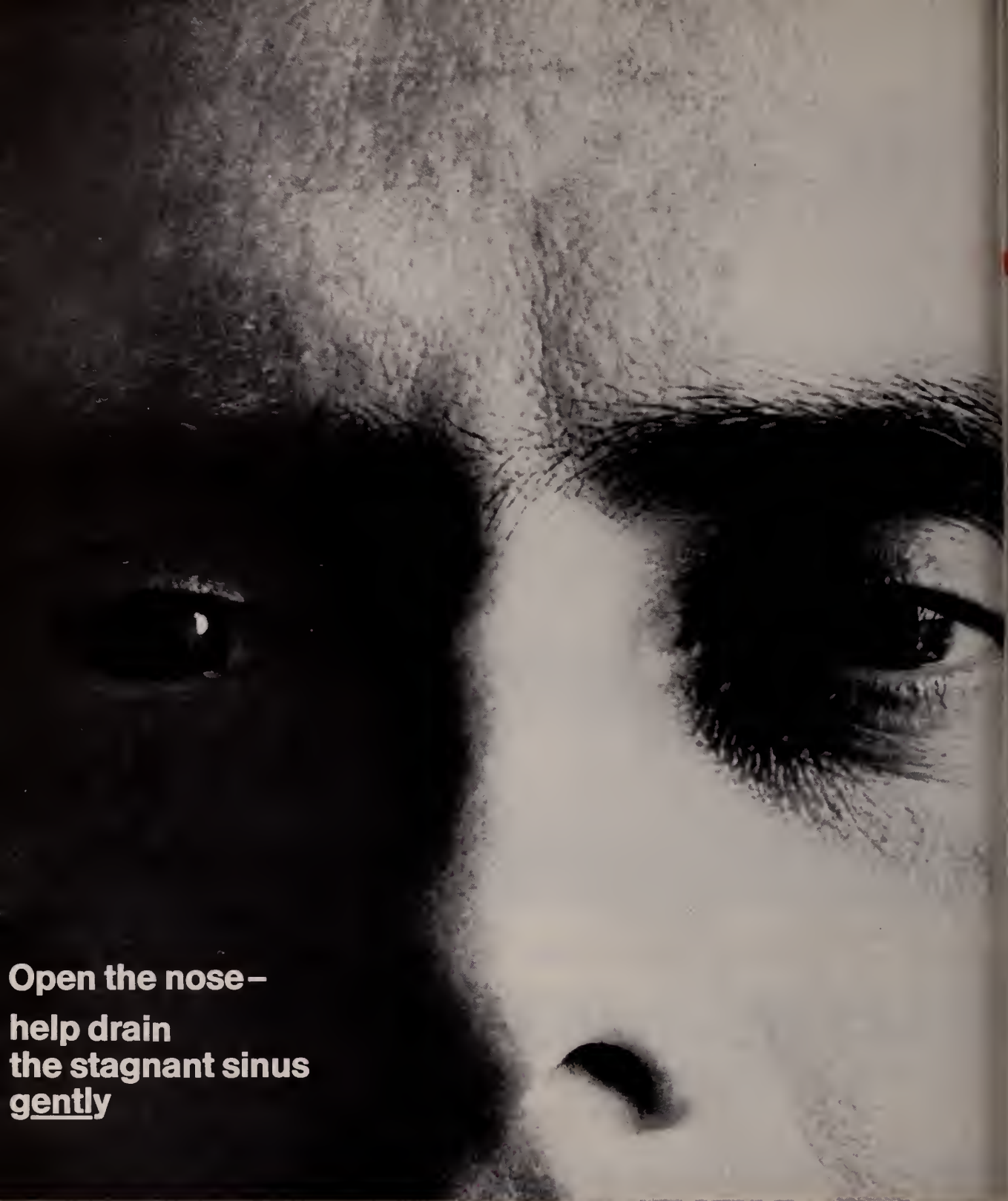
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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.



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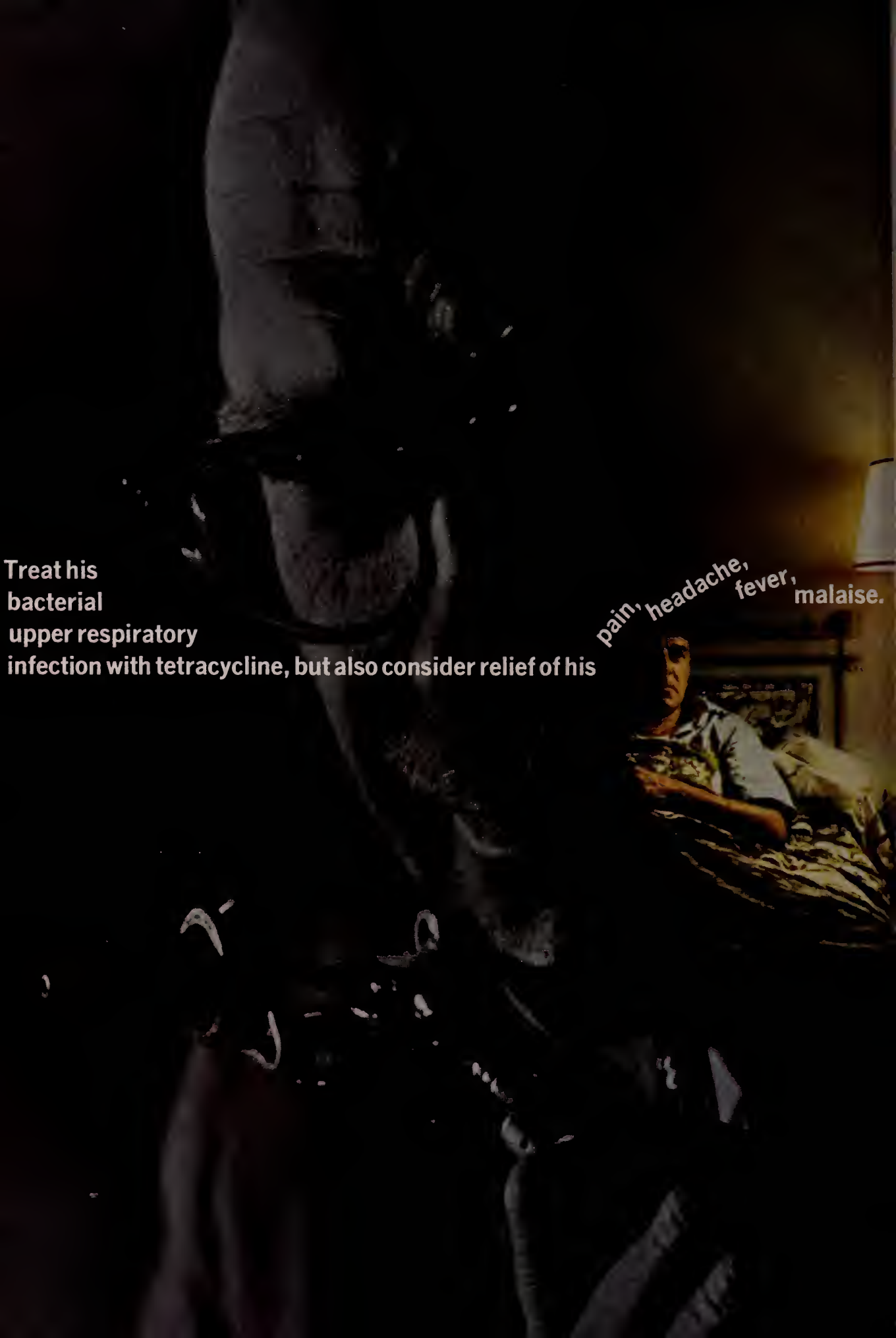
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References: 1. Roberts, C.E., Jr.; Perry, D.M.; Kuharic, H.A., and Kirby, W.M.M.: Arch. Int. Med. *107*:204 (Feb.) 1961. 2. Dowling, H.F.; Lepper, M.H., and Jackson, G.G.: Clin. Pharmacol. & Therap. *3*:564 (Sept.-Oct.) 1962. 3. Editorial: Antibiotics & Chemother. *11*:427 (July) 1961. 4. Baer, R.L., and Harber, L.C.: JAMA *192*:989 (June 14) 1965.

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The JOURNAL
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The Use of Tolazamide in the Treatment of Diabetes Mellitus

Barkley Beidleman, M.D.
Amos L. Prevatt, M.D.
Robert C. Palmer Jr., M.D.

Tolazamide, (N-(1-hexahydro-1-azepinyl)-N[1]-p-tolylsulfonylurea, Tolinase*) a relatively new blood sugar-lowering derivative of tolbutamide (1 - Butyl - 3 - p - tolylsulfonylurea, Orinase*) was found experimentally to be five to seven times more effective than tolbutamide after a single dose and, in diabetic humans, five to 10 times more active on prolonged therapy.[1-5] Initial clinical trials indicated its therapeutic usefulness, good patient acceptance and reasonable freedom from toxic and side effects. The drug was made available to us in June 1962 for evaluation in a typical outpatient diabetic clinic setting.

Procedure and Observations

Sixty-five adult patients attending the Diabetic Division of the Escambia County Clinic for the medically indigent were given a trial of therapy with tolazamide. Eight of these patients are not included in the analysis because their course of therapy was of less than two months' duration. The remaining 57 patients, five men and 52 women, ranged in age from one 28 years old to five over 80 years of age, with a mean age of 61.5 years.

With respect to body type, nine were classified as asthenic, 20 as medium, 20 as heavy and eight as obese. During the course of therapy with tolazamide, 31 gained weight, 22 lost weight and four showed no change.

No apparent relationships were noted between age, habitus or change in weight on one hand and dosage of tolazamide or its efficacy on the other. Loss in weight, when appreciable, was attributable to intercurrent illness, surgical procedures or other easily ascertainable factors and could not be related to the tolazamide.

All patients had maturity-onset stable diabetes mellitus. The known duration of the disease ranged from three months to 28 years, with a mean of five and one-half years.

The patients were routinely evaluated at monthly intervals, with more frequent visits when necessary. Fasting blood sugar levels were measured at each visit in an auto-analyzer (ferricyanide method) and estimates of urine sugar and acetone were made with Clinitest* and Acetest* respectively. Dietary surveys on many of these and other clinic patients had revealed that most patients persisted in following the indigenous low protein, high carbohydrate, high fat diet in spite of attempts to instruct them in the American Diabetes Association exchange system and prescribed menus. Each patient took one multivitamin capsule daily.

Initially, the tolazamide was administered according to a divided dosage plan provided by the supplier. Later, when effective doses had been determined, the entire amount was administered in a single morning dose. No difference in effec-

*The Upjohn Company.

*Ames Company, Inc.

tiveness was noted and, thereafter, all patients were transferred to or started on this single daily dose regimen.

Duration of therapy ranged from two months to 37 months, including 16 courses exceeding 24 months, with a mean of 14 months.

Results

The effective dose of tolazamide ranged from 50 to 1,000 mg. per day. The average dose was 200 mg., but the largest single group of patients consisted of those controlled on 100 mg. daily. No patient received more than 1,000 mg. daily.

Tolazamide was effective in seven patients who had been classified as primary or secondary failures on other sulfonylurea preparations and in two patients in whom phenformin had proved ineffective.

This agent was ineffective in 18 patients who had previously suffered primary or secondary failures on other sulfonylureas and in four patients who had not previously received other similar drugs, giving a corrected failure rate of 10%. Of these, 15 were primary failures and seven were secondary. The latter occurred after satisfactory therapy with tolazamide of from three to six months, averaging 7.33 months. While attempts are still being made to control some of these patients on other oral agents singly or in combination, the majority have reverted to insulin.

In eight patients an apparent tachyphylactic phenomenon was observed. In one of these patients, an average dosage of 250 mg. of tolazamide daily provided good control for four months, following which persistent elevation of the fasting blood sugar level dictated stepwise increases in dosage to an 800 mg. level. At that point, good control was achieved, maintained for three months, then lost and not regained on 1,000 mg. daily to a total of 29 months of treatment. The second patient was well controlled on 500 mg. for seven months, then 800 mg. for four months and, finally, 1,000 mg. for three months with eventual complete failure after a total of 33 months' therapy. Six additional patients have demonstrated this effect, but are well controlled on their current dosages. Whether or not their requirements will escalate further and eventually fail altogether cannot be determined at the time of this writing.

One patient, a 65 year old white woman, experienced a severe pruritic erythematous rash over the face, neck, upper thorax, arms and lower legs after the third daily dose of 100 mg. of tolazamide. The rash began to subside promptly on withdrawal of the drug and cleared completely within 10 days. This dermatitis seemed clearly related to the tolazamide. No other clinical evidence of hepatic, hematopoietic, dermal or other toxic or side effects was noted and no episodes of hypoglycemia attributable to tolazamide occurred.

The results of management were classified according to the level of the majority of the fasting blood sugar levels while adequate drug therapy was given[6] as shown in table 1.

Table 1.—Results Classified

Classification	Fasting Blood Sugar (mg. %)
Excellent	120 or less
Good	121 to 150
Fair	151 to 200
Failure	201 or more

The classification outlined in table 1 has been applied to the groups of patients stabilized at various dosage levels as shown in table 2.

Table 2.—Results of Therapy With Tolazamide

Effective Daily Dose (mg.)	Degree of Control		
	Excellent	Good	Fair
50	3		
100	2	8	1
150	2		
200			4
250		2	
300		4	
350		1	
400	1	1	1
500		1	
600			1
700	1		
750			1
1000		1	
Totals	9 (25.7%)	18 (51.4%)	8 (22.9%)

Thus, slightly more than three fourths of these patients with diabetes responding to tolazamide therapy achieved good to excellent control on single daily doses of 50 to 300 mg.

Summary

Fifty-seven patients with stable diabetes mellitus were treated with tolazamide for periods of two to 37 months, with a mean of 14 months. Tolazamide was effective in nine patients in whom other oral preparations had failed. It was ineffective in 18 other previous sulfonylurea failures, contributing largely to the totals of 15 primary and seven secondary failures on tolazamide in this series.

Slightly more than three fourths of the remaining 35 patients in whom tolazamide has been effective achieved good to excellent control of the diabetes on single daily doses of 50 to 300 mg.

One patient experienced severe generalized dermatitis attributed to tolazamide, which cleared promptly on withdrawal of the agent. No other toxic or side effects were noted. In eight patients, including two of the secondary failures, an apparent tachyphylaxis was observed.

In the outpatient management of diabetes, tolazamide therapy proved to be effective, convenient and easily handled, with an acceptably low incidence of toxicity and no significant side effects.

We wish to acknowledge the assistance of Henry Yonge, M.D., Charles Kahn, M.D., and the internes and residents of the Pensacola Educational Program in the management of these patients.

We are indebted to Mrs. Bess Gauthier, R.N., Miss Nell Godwin and the nursing staff of the Clinic for their hours of unselfish devotion to the welfare of these patients.

Supplies of tolazamide (Tolinase) and a subsidy for secretarial assistance were generously supplied by The Upjohn Company, Kalamazoo, Mich. Multivitamin capsules were kindly furnisbed by Lederle Laboratories, Pearl River, New York, and by E. R. Squibb & Sons, New York, N. Y.

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NEW FEATURE

With this issue, The Journal institutes a section on Government News designed to present abstracted information concerning the numerous governmental directives which are increasingly influencing the practice of medicine on local, state and national levels. This feature is for you, the physician; comments and suggestions are solicited.

Intestinal Parasitism in South Florida

J. Walter Beck, Ph.D.*
Frederick E. Farrer, M.D.**

The proximity of the South Florida area to the tropics and the fact that Miami, in particular, has become the gateway to and from the Caribbean Islands and Latin America favor the exposure of this area to the parasitic diseases of man so prevalent in those regions.

To assess the status of intestinal parasitism in the South Florida area and, in particular, the greater Miami area, a study was made over a two year period of the nature and extent of parasites encountered in stool examinations of patients from a local hospital and of private patients from local physicians. The majority of the patients were from the middle to upper socioeconomic class, of mixed sexes and ages though adults predominated. Approximately 15 were known out of state tourists and about 100 gave a history of having been out of the continental United States though conceivably many more could have been.

Attempts were made in this study with only partial success to obtain a minimum of three stool specimens on alternate days from all patients. A microscopic examination was made on each stool to determine its nature and consistency, to search for adult worms or fragments thereof and to determine the presence or absence of gross blood and mucus. When indicated, a search for motile protozoan trophozoites was made by the direct saline smear. The formalin-ether concentration technique was employed on all specimens and a microscopic search made of a complete cover slip preparation.

Data obtained were compared with those obtained from the Dade County Hospital of Miami (Jackson Memorial Hospital)[1] and the Regional State Board of Health Laboratory for South Florida (Broward, Dade, Collier and Monroe counties)[2] for a one year period and based primarily on a single stool examination per patient. The incidence of intestinal parasitism as indicated by a small survey among the Seminole (Trail) Indians[3] living along the Tamiami Trail is included for comparison because the figures from both the County Hospital and the Regional Laboratory are conditioned to some degree by this segment of the population. Included also are figures from a survey made among the British West Indian migrant sugar workers of the Clewiston areas.[4]

For editorial comment, see page 216

Results

One thousand and eighty-eight patients were examined for parasites. In 52 of 827 hospital patients and in 30 of 261 private patients parasites were recovered from the stools. The total incidence was 7.6%.

The number of patients submitting one or more stools was:

1 stool	2 stools	3 stools	More than 3 stools
550	206	318	14

Among the 82 patients whose stools were positive for parasites, 36 submitted three stool specimens per patient on alternate days. Of these:

19 were positive in 1 out of 3
5 were positive in 2 out of 3
12 were positive in 3 out of 3

Of the 18 patients submitting but two stools per patient on alternate days:

12 were positive in 1 out of 2
6 were positive in 2 out of 2

In 28 patients the stools were positive for parasites on the basis of one stool examination per patient.

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Discussion

In order to compare figures from this study with those from the County Hospital and Regional Laboratory it was necessary to determine the incidence of parasitism based on the number of stools examined rather than the number of patients. Accordingly, our survey revealed an incidence of slightly less than 5% while the County Hospital gave a figure of approximately 20% with the Regional Laboratory reporting over 25%. It is significant that whereas the segments of the population studied in our survey were chiefly of the middle to upper socioeconomic class, those reported in the other two surveys were chiefly of the middle to lower socioeconomic class. Accordingly, it is apparent that whereas intestinal parasitism is common in the lower socioeconomic class in South Florida, it is relatively low in the middle to upper class. The high incidence of parasitism among the Seminole Indians (90%) helps to raise the general incidence rate in the Regional Laboratory report and in that of the County Hospital. The high incidence (86%) of intestinal parasitism among migratory workers in the Clewiston area further indicates that parasitism is sustained among the lower socioeconomic group and, although not in the South Florida area, suggests that similar workers in the southern part of the state might be similarly infected.

It is of particular interest to note that among the 36 patients with positive stools submitting three specimens per patient for examination, only 19 showed parasites in all examinations. This finding suggests that in the remaining 24 the parasites could have been missed had less than three stools per patient been examined. Likewise, among those submitting but two stools some parasites may also have been missed. Since 550 patients out of the 1,088 examined submitted but one stool per patient, it is safe to conjecture that some of these patients had parasites which were missed and that, had three stools per patient been examined, the 7.6% figure reported would have been higher.

Protozoan trophozoites occur most commonly in soft, diarrheic stools. Such specimens should be examined immediately by direct saline smear. When trophozoites of the amebas are encountered, difficulty usually occurs in identification since motile amebas of the different species may closely resemble one another. In such instances only by the preparation of iron-hematoxylin smears can such organisms be properly identified. This procedure is time-consuming and not usually employed in most small laboratories. On the other hand, except in cases presenting the amebic dysentery syndrome where typical trophozoites of E. histolytica are readily recognizable, most patients in the United States show cysts in the stool. Cysts are more reliable for identification purposes and, with prolonged and careful search, can usually be found. Thus normally passed stools, in most instances, are desirable for routine examinations. Refrigeration preserves the cysts for study for several weeks provided drying of the specimen is avoided, a convenience of practical importance for most physicians and hospitals.

Nature and Extent of Intestinal Parasitism in South Florida

ıd Species	Present Study* (1977 exams.)			Jackson Memorial Hospital (2383 exams.)	Regional Health Laboratory (12,325 exams.)	Seminole Study (75 exams.)	British West Indies Migratory Workers (140 exams.)
	Hospital	Private	Total				
ba histolytica	6	5	11 (0. 5%)	0. 5%	0.09%	21.3%	12%
ba coli	6	2	8 (0. 4%)	3. 6%	0.05%	38.6%	26.4%
x nana	13	8	21 (1.06%)	1. 8%	5.09%	25.3%	44.3%
ba bütschlii	1	0	1 (0.05%)	0.0 %	0. 9%	1.3%	6.4%
eba fragilis	0	0	0 (0.0 %)	0.01%	0.0 %	0.0%	0.0%
tix mesnili	0	0	0 (0.0 %)	0. 4%	0. 1%	2.6%	0.0%
amblia	22	7	29 (1. 4%)	4. 5%	3. 8%	14.6%	11.4%
nas hominis	0	1	1 (0.05%)	0. 2%	0.0 %	0.0%	0.0%
ıs vermicularis	2	2	4 (0. 2%)	0. 5%	3. 5%	0.0%	0.0%
trichiura	3	4	7 (0. 3%)	8. 6%	7. 4%	3.0%	35.7%
umbricoides	1	2	3 (0. 1%)	5. 7%	7. 5%	0.0%	5.0%
ms	2	0	2 (0. 1%)	1. 4%	2. 8%	45.0%	50.7%
ides stercoralis	1	0	1 (0.05%)	0. 8%	0.0 %	9.3%	13.0%
aginata	0	4	4 (0. 2%)	0.0 %	0.02%	0.0%	0.0%
epis nana	0	0	0 (0.0 %)	0.04%	0.02%	0.0%	0.0%
cephalus latus	0	0	0 (0.0 %)	0.0 %	0.02%	0.0%	0.0%
ma mansoni	0	0	0 (0.0 %)	0.04%	0.0 %	0.0%	0.0%

Parasitology Laboratory.

Purging of the patient may succeed in flushing organisms from the cecum but, unless cysts are encountered, the difficulty of trophozoite identification, as mentioned previously, is encountered. Sigmoidoscopy likewise presents its problems to those not thoroughly familiar with the trophozoite stage of E. histolytica. Too frequently, macrophages, with their motility, are mistaken for amebas. Scrappings or biopsy specimens taken from sites other than the lesion itself rarely if ever will reveal the parasites. On the other hand, the typical punctate lesion, if amebic in origin, will reveal the trophozoite of E. histolytica with most of the identifiable characteristics if examined immediately.

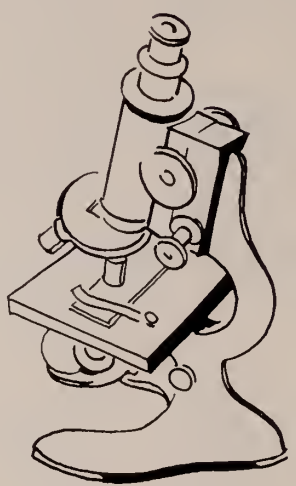
It cannot be emphasized too strongly that repeated stool examinations are necessary in the examination of patients for intestinal parasites. Many parasites are cyclic in their appearance, being more numerous at one time than at another. This consideration, the inherent human error factor and inadequacies of technique necessitate repeated stool examinations. No limit can be set upon the number to be examined, the more the better. We have arbitrarily settled upon three on alternate days because of the convenience to the patient, the physician and the laboratory involved. Three stools can be examined in the course of a week. The patient is not held unduly long and a high percentage of recovery of parasites is obtained. If deemed necessary the regimen can be repeated.

Grateful acknowledgment is made to Peggy McCallen for the compilation of the data in this study.

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A New Mode of Psychiatric Treatment

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The purpose of this paper is to present to the medical profession a new hospital treatment of depression. This treatment is proving to be of value in other psychopathological and psychophysiological states. It is designed for use in the hospital and to give maximum exploitation of the unique properties of the "antidepressant drug" amitriptyline hydrochloride (Elavil).

The treatment evolves from my original observation that imipramine hydrochloride (Tofrānil), when administered intramuscularly, facilitates catharsis, abreaction, and the working through of psychiatric symptoms when combined with psychotherapy. This basic observation was confirmed by continued study with tape recordings of psychotherapeutic interviews with patients receiving imipramine hydrochloride by intramuscular injection. Since amitriptyline hydrochloride is a closely related chemical and an "antidepressant drug," I examined, with the aid of tape recordings, depth psychotherapeutic interviews and proved to my satisfaction that amitriptyline hydrochloride also facilitates catharsis, abreaction, and symptom resolution. The basic data from which these conclusions were reached are filed away on tape and any interested and qualified investigator would be welcome to examine these tapes. The discovery of this clinical effect of these two "antidepressants" was reported in an unpublished paper read before the Florida Psychiatric Society in October 1964.

About the Drugs

Hypnosis and drugs are known to be agents which bring about catharsis and abreaction. Each drug, such as alcohol, barbiturates and amphetamines, would seem to produce a different and unique quality of emotional tone accompanying the abreaction. So it is with imipramine hydrochloride and amitriptyline hydrochloride. The patient abreacting with amitriptyline hydrochloride feels much less overtly anxious than does the same patient taking imipramine hydrochloride. Both drugs permit a very natural quality of emotional tone during abreaction and the material is always clearly remembered. With narcosynthesis as with hypnoanalysis, the material is usually lost by the patient but not to the physician. Since the material is not usually again repressed when imipramine hydrochloride and amitriptyline hydrochloride are used, the patient remembers and easily makes the connections for himself. True insight is thereby achieved into the relationship between past life experience and perception of present events.

Clinically amitriptyline hydrochloride differs from imipramine hydrochloride in that it has an initial drowsy effect, lasting three or four days, and generally requires a smaller and more predictable daily amount of drug to produce results. Both drugs are known to be effective "antidepressants."[1-4] The initial reaction to amitriptyline hydrochloride administered intramuscularly is that of drowsiness, relaxation of tension, and a tendency to sleep and dream. This initial reaction would seem to be an altered state of consciousness in which the patient wants to go to bed, says little, and does not move much, but will feed and toilet himself, walk to the laboratory willingly, and answer questions in a brief but pertinent fashion.

The Treatment Procedure

The acutely disturbed, often suicidal, patient is given the following statement prior to going to the hospital: "You are going to be a patient in an open floor psychiatric ward. No one will try to make you go, or make you do anything. The first few days you are there your job will be to rest, relax, sleep and eat, and you will probably dream.

† Deceased, Feb. 3, 1966.

It is our job to satisfy your every need. We try to anticipate these, but should we fail to do so, we want you to tell the nurses or doctor your desires. Whatever you want we will supply. In order to help you relax and rest, you will be given injections for three or four days. Your job is to rest and we will talk about your problems after you are feeling better." On the patient's arrival on the floor, the nurse reinforces these suggestions.

Orders on the chart are written for: (1) modified anaclitic nursing care; (2) amitriptyline hydrochloride, 25 to 35 mg. intramuscularly every six hours around the clock for 72 hours; (3) promazine hydrochloride (Sparine), 100 mg. by mouth every six hours around the clock for 72 hours; (4) multivitamin medication intramuscularly, 1 cc. daily for three days; (5) amobarbital sodium (Amytal Sodium), grains 3 at bedtime as required if absolutely needed for sleep. Diet and laboratory work are ordered according to the patient's medical needs. Visitors are permitted or denied according to the patient's wishes.

Each morning on rounds the doctor is given a verbal report on each patient for the past 24 hours by the chief ward nurse. She informs him what has been going on, and he helps her with problems creating anxiety in her. The doctor then visits each patient. During the first day or so, when the patient is very sleepy, the doctor merely suggests continued sleep and rest and inquires about possible remembered dreams. On the third or fourth hospital day intramuscular injection of amitriptyline hydrochloride is discontinued and the drug given in approximately equal doses by mouth. At the same time the doctor invites the patient to leave the bed and come to the conference room "where we begin to talk about the problems" (begin depth psychotherapy).

At this time patients, as described in the illustrative case, begin to be up and around, to explore the hospital, and to socialize. Dyadic, triadic, and spontaneous group relationships are formed. They work with their hands in occupational therapy. They have bull sessions, parties, games, and shopping trips. They discuss the hospital, doctors, nurses, treatment, and each other. When I have more than four or five patients in the same hospital ward, there is a tendency for them to unite spontaneously into a subgroup of the total milieu. These patients have in common the same doctor.

Each morning thereafter the patient is seen for seven to 10 minutes psychotherapeutically. To these interviews the therapist comes already briefed by the nurse on the patient's behavior of the previous day. He observes his patients interacting with each other as they wait for, and decide among themselves, who is to talk with the doctor next. He correlates this reported and observed acting out in the social milieu with what he knows and is learning of the emerging transference and countertransference in the doctor-patient relationship, in the patient to the staff relations, and in patient to patient relations. These transference reactions are called to the attention of the patient as they are manifest in the social setting. In contradistinction to the "classical" psychoanalytic technique, they are brought to the attention of the patients as soon as they seem receptive and they can be properly presented. The "classical" technique generally defers transference interpretation to the last.

A simple example is the case of a 36 year old white divorced and remarried woman who was hospitalized because of growing anxiety, depression, and withdrawal. She had many growing phobic mechanisms and had obsessional trends. When she spoke, she went into endless detail in order to make her point. As the days went by she was always the last, or one of the last, to see the doctor. He noted that she chose to give way to other patients and wondered when she would quit this behavior. In the meantime, each morning in the interview, she bemoaned the fact that her mother liked her sister better; that her sister paid little attention to her; that she had abandoned her first two children of the first marriage to her husband, feeling herself an unfit mother, et cetera. One morning she was at the head of the line, asking to be first. Both she and I knew she was better, and was about ready to go home and to continue outpatient treatment. I discussed with her the change in her behavior toward me and other patients, pointing out that she was behaving here and now as she had in her early home environment.

In order to forestall unfortunate acting out, each interview is ended with the question, "What would you like to do today?" If the patient proposes doing acceptable and constructive things, the doctor says, "Fine, we will see you tomorrow." If unfortunate acting out is proposed, the interview is continued until the patient finds a better plan for the day's activities.

When the patient begins to talk of going home, the doctor encourages this acting out provided both he and the patient agree that the patient is ready. Prior to discharge the patients are required to spend 24 to 36 hours at home in order to test themselves and their own reactions to the home situation. If the visit goes well, they are asked to come back with the next of kin for the terminal hospital interview. If it does not go well, they are asked to return prematurely and plan to spend a few more days.

The terminal hospital interview also involves the next of kin. The couple is given a chance to discuss problems that may have arisen during the visit at home. Plans for follow-up outpatient care are made and prescriptions for drugs written. The patient is then discharged, usually for continued individual and/or group psychotherapy in the office.

Recently we have been combining promazine hydrochloride with amitriptyline hydrochloride in a ratio of about 4 to 1. This combination produces an even more relaxed and pleasant state. It is well known that promazine hydrochloride, like amitriptyline hydrochloride, produces an altered state of consciousness when administered intravenously. It is known that chlorpromazine hydrochloride (Thorazine) is one of the best "antipsychotics" and tends to produce depression. Promazine hydrochloride seems to relieve tension and agitation and does not give the feeling of depression.

The Treatment Setting

The acutely disturbed patient is placed in a hospital in a modified anaclitic nursing care[5] setting. Anaclitic nursing care is a method of care perfected at Duke University for use in the severely ill, uncooperative, and ambivalent psychosomatic patient. With this kind of care the anaclitic nurse is encouraged to fulfill all of the patient's needs and demands and to do so with as little conversation as possible. This approach tends to facilitate regression to the infantile state with the nurse playing the role of Good Mother. The regressing ambivalent patient then splits the mother figure into Good Mother and Bad Mother and the father figure into Prince Charming and the Devil. These images are projected onto the screen of the world and people around. The anaclitic therapist keeps track of these projections and manipulates the transference reactions. There will always be Good Doctor whose medicines work and Bad Doctor whose medicines do not or did not work.

The strict anaclitic nursing care is very much like that given the patient with an acute coronary thrombosis. He is regressed, put in an oxygen tent, and this therapy is carried out without much conversation because the walls of the tent prevent it.

In this new method of treatment of depression, patients are offered anaclitic nursing care plus the opportunity to use the staff and interested and sympathetic fellow patients as sounding boards when they abreact and relive previously repressed material. The physiological impact of amitriptyline hydrochloride and promazine hydrochloride reenforces the regressive trends in the same way that lowering the blood sugar does in the insulin treatment.

Report of Case

A 40 year old white divorced and remarried board-certified practicing physician was admitted to the hospital during the first week of August 1964 because of thick speech, ataxia of two or three weeks' duration, and ankle edema. He had given up an academic medical position five years previously to go into private practice. He was not happy in practice and became progressively more depressed. He had been a total abstainer from alcohol prior to his third year in medical school and thereafter his use of alcohol gradually grew. For five years prior to admission he was using alcohol every night as a daily routine, mostly, he thought, as an aid to sleep, in addition to barbiturates. He was nervous and had tried various "tranquilizers." He did not get along with his fellow practitioners and was terrified of competition in his specialty. On May 11, 1964, infectious hepatitis developed and forced him to abstain totally from alcohol. He remained away from his practice until July 11, and then became profoundly depressed, as many patients do following hepatic disease. He substituted addiction to ethchlorvynol (Placidyl) for addiction to alcohol. Ataxia, slurred speech and ankle edema developed, and he would go off into what his wife described as "hypnotic states."

In the hospital he was examined for toxicity due to hepatic disease and neurological disease. His tests were all normal; no neurological illness was detected other than acute brain syndrome due to ethchlorvynol. He was profoundly depressed and agitated and wanted to jump into the river. His brothers were called from the Midwest and they implored him to remain in the hospital, accept psychiatric help, and not leave against medical advice. All this was to no avail until he was given amitriptyline hydrochloride intramuscularly and was placed in modified anaclitic nursing care in a private room on the open psychiatric floor. At that time we did not combine amitriptyline hydrochloride and promazine hydrochloride. He was discharged in 10 days after beginning psychiatric treatment.

The material that follows is taken from a tape recording made five weeks after he had returned to his home and practice. It was made because he was a highly verbal and articulate man and well acquainted with drugs. The material is not an attempted psychotherapeutic interview, but is an attempt to have him describe the subjective experience of his treatment, which was a very pleasant one. It was made on October 3 at the time of his second outpatient visit.

Verbatum Transcription of Tape Recording:

DOCTOR: "Doctor, it is nice to have you back this afternoon and we are glad things are going so well. I wonder if you would tell what it felt like to be given Elavil, 30 mg. intramuscularly?"

PATIENT: "Well, at the time of the first injection of Elavil, I was extremely depressed and agitated and felt very insecure and I was afraid that there was no way up for me; and at that time I began to weep and—ah—did not want to cooperate. I wanted to go home desperately. However, when the nurse came in and I was given the injection of Elavil, the first sensation I noted was approximately three up to five minutes after the injection; and I had the sensation that maybe it was not so bad and maybe things could get better and where I felt it was a lost cause, there was hope. Then when I noted a nice feeling of drowsiness, and I felt as if I were relaxing and the tension seemed to be leaving—and then what I sought most came—and that was a restful sleep. I slept for approximately until the time for the next injection and I welcomed the injection not knowing what drug it was because it gave me for the first time in a long time real relief."

DOCTOR: "How long?"

PATIENT: "Well, I would say it had been really three years before I had felt as relaxed and felt I was without this terrific anxiety."

DOCTOR: "Thank you. Now you made some comments previously, on looking back, about the frequency of the injections, saying you would get a little bit restless."

PATIENT: "Yes, I would notice that when the four hour period would be up that I would notice that I would feel more tense, and that I became a little more anxious and that I felt a great sense of relief when the nurse came in with the next injection. I had no thought whatsoever of the pain of the injection. I felt like this was a wonderful thing and I wanted to re-establish the plateau of well being that I felt shortly after the drug."

DOCTOR: "Now as time went on and the drowsy effect of Elavil wore off, will you tell the subjective experience of being ready to be up and around a little bit and being — —"

PATIENT: "Yes, I felt this—that on first being there I wanted to stay in my room; I did not want to have any discussions with the hospital personnel or nurses; and after receiving the Elavil, after I noticed the second day, that I had a desire to communicate with people and began to actually feel in a sense jolly; and that I wanted to kind of explore my surroundings. Whereas prior to that time, I wanted to be very much alone and with no conversation."

DOCTOR: "Go right ahead."

PATIENT: "Then I noted that when I—ah—I would walk in the hall and ah, where I felt I wanted to avoid people, I felt free to talk with people, and I felt confident to go to the cafeteria where a lot of the indecisions that I felt—what should I do—even to the point of which foods to eat. Then I noted I could more easily make decisions, and I felt I could be more definite in my decisions and I definitely felt more secure. And I felt I was improving and that gave me a great stimulus of a drive and a desire to come back and overcome my difficulties and seek a victory."

DOCTOR: "All right—now I think essentially every morning we worked a little bit psychotherapeutically."

PATIENT: "Yes, that is true."

DOCTOR: "I think essentially in the hospital the doctor relived, psychotherapeutically, the experience of the acute brain syndrome."

PATIENT: "Yes."

DOCTOR: "It was almost like doing psychotherapy on a person who had experienced a bad dream."

PATIENT: "Yes."

DOCTOR: "And they work through this experience. He went home in 10 days; and how have things been going since?"

PATIENT: "Since I have been home things have gone extremely well. My wife refers to me as just a different person. I noticed that the little things that seemed to be a—a—ah— large obstacle have really vanished and I find I have confidence in what I do—I ah—feel that I am certainly mentally acute, my memory is much better, ah—I do not have the fear, as I once did on my first going home, that I would desire avidly to return to alcohol. And ah—on the Elavil I feel quite secure and I do not feel its need and have not in any way taken alcohol."

DOCTOR: "All right—ah—you're taking 75 mg. a day?"

PATIENT: "Taking 75 mg. a day."

DOCTOR: "You sleep?"

PATIENT: "Yes, I sleep very well."

DOCTOR: "Sleep well without sedation."

PATIENT: "Right."

DOCTOR: "You told me when I first saw you that you have always been a somewhat compulsive person."

PATIENT: "Yes."

DOCTOR: "What is happening to these compulsions?"

PATIENT: "I have noticed that—ah—when I have—ah—a compulsion—ah—feeling that I must do this or do that at this moment; I have now begun to say to myself: 'well, this is not such a big thing' and 'it doesn't have to be done just at this moment; and perhaps if you let a patient wait, it's all right because life will still go on'; and I felt that I have been able to discard a great deal of the little petty things that I felt had to be done on the moment and that I had to accomplish this on the moment. I was then more able to look at a long view of living and more evaluate myself and re-establish really a different system of values."

DOCTOR: "Doctor, do you think this has in any way affected your capacity to speak? To talk?"

PATIENT: "No, I do not. The only thing that I do observe is that I do get a dry mouth, usually about two hours after ingestion of Elavil and that I feel that I would like a drink of water to more or less increase—I mean to decrease the dryness in my mouth."

DOCTOR: "Is there anything else that you have observed about the drug?"

PATIENT: "The only thing that I have observed which might be considered a side effect, would be that—ah—I have a much more—a desire to—ah—I notice I had a greater frequency of the desire to urinate—yet at the time to commence the act I had to put actually some concentration to start the flow; but I was perfectly able to empty my bladder without difficulty, and, of course, I did notice a more thirst and my fluid intake was definitely increased."

DOCTOR: "How—how do you think you are now? In your own evaluation?"

PATIENT: "In my own evaluation I am better than I have ever been in my recent memory, and I feel good, feel self confident, I have drive with energy, my memory has improved."

DOCTOR: "You are better than you were when you were here last—this is obvious."

PATIENT: "Oh yes sir—definitely so."

DOCTOR: "Anything else you would like to say?"

PATIENT: "Well, ah—I have taken other tranquilizing drugs, not that we would consider Elavil necessarily a tranquilizer; and, ah—I had undesirable side effects, which I do not experience with Elavil. And this is the only drug that I have ever taken that seemed to fit my need, to make me a constructive individual, and keep me mentally awake with a desire for a sense of doing a job well done."

DOCTOR: "I would like you to describe the change that has taken place, if you would, in your relationship with your wife—the interpersonal relationship."

PATIENT: "Well, I feel that our marriage has been better in all aspects in the past month, that I have been

taking orally, ah—Elavil at 25 mg. three times a day. I have noted that we are more congenial on being alone. We are able to share problems much better. Ah—I noted that I can have something bothering me, of which I have thought about and show mild signs of being depressed; that I can now verbalize my problem with her where we can both share it. And what would seem in the past to be a big problem now seems to vanish and—ah—I noted I can avert feelings that ultimately I know will lead to a depression; and I note that we share both in companionship, and also from the physical aspect of sex I find that it is all much better in our marriage."

DOCTOR: "Thank you very much. I think that it also should be on the record that as part of the therapeutic effort the doctor's wife has talked with the psychotherapist here in my office, once while he was in the hospital, and each time (which is twice now) that they have come back as out-patients."

"The point that I think is important about Elavil is that people are better able to talk about their problems and getting these problems out in the open—that is, the communication between husband and wife, or doctor and patient, or doctor and his office nurse is much improved."

PATIENT: "Yes."

DOCTOR: "And as these problems get kicked out in the open the problems are resolved. Does that make sense to you?"

PATIENT: "Yes it does."

DOCTOR: "Therefore, we have called this the communication drug."

At the part beginning with the second "thank you very much," I attempt to speak ("voice over") to the listeners of the tape. The machine is turned off and the patient continues to talk. He reports that the condition of his skin is better than it has been in years (many patients note this skin change). He also noted that he and his wife agree that whereas his hair grew white while he was so sick, it is now getting dark again. This alleged folie a deux is obviously a delusion. The white-haired therapist is left uncertain as to the structure of this delusion but suspects the patient is dropping his unconscious identification with his doctor and while using a compulsive ritual of Elavil, 25 mg. three times a day.

Experience with the Treatment to Date

So far we have treated about 50 patients approximately as stated. As we have gone along, we have learned more about the drug and have better standardized the treatment, and the hospital staff has learned better how to supply and manage modified anaclitic nursing care. All patients have been private patients, most of them presenting predominantly depressive symptomatology. Symptoms such as paranoid states, tics, spasms, obsessional states, addictions and habituations have also responded well to the treatment. Total hospital days seem to be reduced by about one third or one half the expected time for the various states in which the treatment has been tested.

While I was attending an out of town conference, one patient died on the fourth day of treatment. He was a well known chronic depressive schizophrenic who had had four previous hospitalizations; on two occasions he was given electroshock therapy, once was given insulin, and on the remaining occasion was given only psychotrophic drugs and psychotherapy. He died suddenly on the fourth hospital day. Autopsy revealed obesity, moderate arteriosclerosis, acute fatty degeneration of the liver, and visceral congestion consistent with a terminal ventricular fibrillation. He had withheld the fact that he had consumed a fifth or more of alcohol daily for six months, and for one year had complained to his wife of periodic irregular heart beat. For several patients the treatment is considered a failure because they have left the hospital against advice, and one 73 year old male diabetic patient has not responded as yet to any treatment of depression. A manic patient became more excited.

I have seen depressed dry alcoholics relive and work through the experience of delirium tremens 10 or 15 years ago. I have successfully treated two patients with chronic schizophrenic reactions manifested by auditory hallucinations and other projective mechanisms. I have successfully treated one middle-aged obsessive compulsive woman (a hand washer) whose compulsive rituals had been growing since well before adolescence. I have seen patients relive the experience of electroshock therapy given with and without anesthesia. Two patients have relived and recalled previous hypnotic sessions.

I have also experienced the precipitation of an acute psychotic reaction, one with amitriptyline hydrochloride and one with imipramine hydrochloride in two depressed schizophrenic patients by giving the drug to them orally as outpatients. The results were disastrous for both patients. Kuhn[1] in his original paper on imipramine hydrochloride, found it helpful for depression but not helpful for the schizophrenic. In my opinion, unless one is prepared to treat psychotherapeutically and help the patient work through the latent psychotic reaction the drugs may release, they should not be used. These drugs are like a lever that loosens the top of Pandora's box. One must be prepared to deal with its contents when they emerge. We find that standard electric shock, chlorpromazine hydrochloride, and amobarbital sodium (Amytal Sodium) seem to facilitate repression, while imipramine hydrochloride and amitriptyline hydrochloride facilitate uncovering. Formal statistical analysis of the data so far would seem an insurmountable task because of the innumerable variables of patients' conditions, changes in doctor-nurse hospital routine and other intangibles. Since this work is carried out in a private practice setting, blind or double blind

procedures are impossible. From crossover experiments with the same patient, amitriptyline hydrochloride would seem to be the drug of choice unless, for some reason, its drowsy effect is undesirable.

Contraindications

We believe that the treatment is contraindicated in latent schizophrenics, glaucoma, severe hepatic and renal impairment, brain syndrome, coronary disease, chronic pulmonary disease, and in old people in whom hypostatic pneumonia might develop.

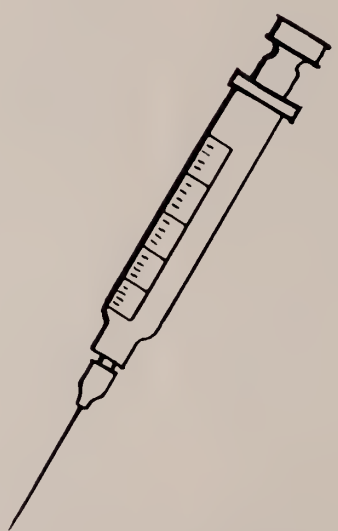
Summary

A new treatment of depression, which may prove useful in other psychopathological and psychophysiological states, is presented. The treatment is designed to exploit that property of amitriptyline hydrochloride which facilitates working through in the psychotherapeutic process and the unique initial drowsy effect of this drug. The patient is placed in a modified anaclitic nursing care setting and the physiological impact of drugs is used to increase the patient's trend to regression. A firm positive tranference reaction is established. The patient is then usually ready to return home and continue with outpatient individual and/or group psychotherapy. The treatment has been used on about 50 patients. The results can be evaluated only on the empirical clinical level. Hospital time for patients treated this way is apparently reduced by about one third or one half of the time required by other methods known to me. An illustrative case is presented. Contraindications are listed.

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Management of Alcohol Withdrawal States

Helen M. Williams, M.D.*

For the alcoholic, acute intoxication and withdrawal period present the prospect of serious and sometimes fatal complications. Even in the absence of serious reactions, the alcoholic in withdrawal poses a difficult and time-consuming problem.

Anticipating the Severity of Withdrawal

Differentiating between the patient who will just have a hang-over in the morning and the one who will be critically ill remains difficult. Nevertheless, these are a few clues which may at least alert the physician to the likelihood of a difficult withdrawal period: (1) The first is age; many types of serious withdrawal appear to become considerably more frequent after the age of 35 (table 1). Thereafter the complications appear rather rapidly within the next five years. (2) Another one is the drinking pattern; the person who drinks every day and particularly the one who sips around the clock and is rarely without alcohol in his blood stream is decidedly more likely to have physical disturbances when alcohol is discontinued than the patient who drinks periodically. (3) Of course, the longer the drinking bout and the larger the quantity consumed, the greater the difficulty experienced in drying out (table 2). (4) Other physical illnesses, particularly cardiovascular, respiratory, renal, hepatic or pancreatic disease, present serious problems when they complicate alcohol withdrawal. (5) The concomitant long term use of sedative or ataractic drugs with alcohol also makes detoxication difficult.

Table 1.—Average Age at Which 795 Alcoholic Patients First Experienced Selected Events**

Item	Average Age
First drink	17
Regular drinking	21
Drinking on the job	29
Excessive drinking	30
First warned about on-job drinking	33
First bender	34
First blackout	35
Uncontrolled drinking	37
First left or lost job from drinking	37
First severe shakes	38
First delirium tremens	39
First convulsion	40
First treatment	42
First entered Alcoholic Rehabilitation Center	45

**Compiled from Williams, James H.: Characteristics of an Alcoholic Sample, Florida Alcoholic Rehabilitation Program, 1964.

Typical Withdrawal Reactions

The withdrawal symptoms begin as the patient's blood alcohol level falls below the level to which he has become habituated. Typically this is eight to 12 hours after his last drink. In some cases, however, it may begin while he is still sipping a little in an effort to taper off. The reaction, if untreated, increases in severity during the second and third days and, unless complications have developed, begins to improve after the third day. Nevertheless, seven to 10 days usually elapse before the patient has actually recovered from the episode.

Table 2.—Relation of Amount of Whiskey Consumed and Duration of Drinking to Severity of Withdrawal Reaction*

Amount/Day	Duration of Drinking	Expected Withdrawal
1 pint	2-10 days	Mild—shakes
1 pint	11-21 days	Moderate—hallucinations
1 pint	Over 21 days	Severe—delirium tremens
1 fifth	2-3 days	Mild—shakes
1 fifth	4-7 days	Moderate—hallucinations
1 fifth	8 or more days	Severe—delirium tremens

*Variations from this schedule are numerous; nevertheless, it provides a guide by which the physician may initiate treatment.

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In figure 1 an attempt is made to diagram a typical withdrawal pattern.

The complications of the withdrawal period are numerous, and range from those which are merely annoying to the patient to those which are of critical importance. Probably those which come to mind most quickly are shakes and delirium tremens. Actually these seem to be different degrees or intensities of the same phenomenon, the mildest expression being a subjective sensation of quivering or shaking which the patient calls the "inside shakes," a more severe symptom being the gross tremor with vivid nightmares and hallucinations, and finally delirium tremens being the extreme form. The cause of these symptoms is still not definitely known. They appear to be related in part to the actual withholding of alcohol from the system and they are usually relieved temporarily by giving alcohol or, at times, a tranquilizer. They also seem to be influenced by the patient's state of health and nutrition, by infection, trauma, surgery or complicating illness. Once delirium tremens develops, the mortality is at least 10% and in many series much higher, occasionally up to 25 to 35% where accident victims are numerous.

Although delirium tremens may develop rapidly, it rarely occurs suddenly without premonitory signs. Restlessness and agitation become marked; the patient paces the floor, rearranges his room or packs his suitcase. He becomes more anxious and repeatedly asks the nurse if his condition and behavior are satisfactory. At the same time he becomes less willing to follow instructions and generally louder in his talk and less cooperative. He professes extreme tiredness but is unable to sleep or even be still. He begins to misidentify persons he sees and finally to hallucinate. This condition develops over a period of several hours, more often than not, during the late afternoon and night hours. If the patient can be given heavy doses of phenothiazine or sufficient sedative drug to induce sleep during this period, frank delirium can usually be prevented. If it is permitted to progress until morning, delirium tremens is usually established.

In milder withdrawals, motor symptoms may predominate over psychic, and complaints center

Diagram of Expected Natural Courses of Alcohol Withdrawal Reactions with and Without Delirium Tremens 8.

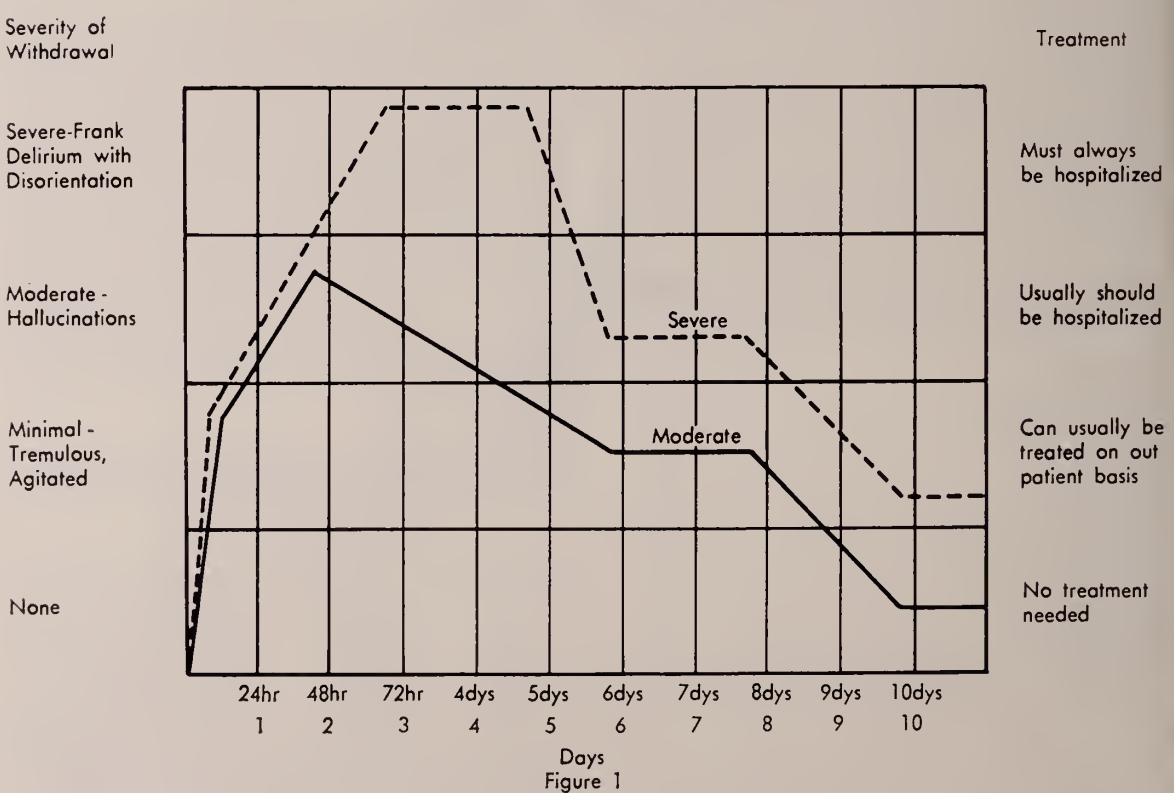


Figure 1

Table 3.—Withdrawal Symptoms Frequently Encountered During Drying Out Period

SYMPTOM	POSSIBLE CAUSES	PREVENTION	TREATMENT
Nausea and/or vomiting	Gastritis; hypermotility	Antiemetics and antacids	Same
Loss of appetite	Gastritis; early cirrhosis	Usually unnecessary	Usually improves spontaneously with general improvement
Diarrhea	Hypermotility	Usually unnecessary	Routine antidiarrhea prescription
Gas; indigestion	Gastritis; ulcer	Antacids may help	Antacids; if severe, anticholinergics
Cramping, abdominal	Spasm of hypermotility	Antispasmodics	Same
Bleeding	Gastritis, ulcer, cirrhosis		If severe, constitutes emergency; if minor, antacids or ulcer regimen may help
Agitation	Alcohol withdrawal	Ataractics; sedatives	Same
Shakes	Alcohol withdrawal	Ataractics plus muscle relaxant	Same
Hallucinations	Alcohol withdrawal	Ataractics	Same
Insomnia	Alcohol withdrawal	Ataractics; sedatives if necessary for short time	Same
Memory impairment	Partly to vitamin deficiency	Usually already present when seen	Vitamins, improved general nutrition
Muscle cramps	Vitamin and mineral deficiencies	Vitamins and minerals	Same
Numbness; tingling	Thiamine deficiency	Thiamine	Same
Vertigo; staggering	Thiamine deficiency	Thiamine	Same
Disturbance in equilibrium	Thiamine deficiency	Thiamine	Same
Convulsions	Unknown	Anticonvulsant	Same
Palpitations	Vagal stimulation; myocardiopathy	Ataractics; if myocardiopathy, manage in usual way	Same
Rapid pulse	Same	Same	Same

around severe tremors which interfere with eating and activity, muscle twitching and muscle cramps. Among the more toxic patients in this group, neurologic and special sense disturbances are likely to be troublesome and disturbances in vision, hearing and equilibrium are frequent. Seizures occasionally occur. In addition, numbness and tingling of the extremities and severe generalized itching of the skin cause a great deal of concern to the patient.

Other Complications of Withdrawal

Besides the classical shakes, hallucinosis, and delirium tremens, numerous other symptoms are prominent during alcohol withdrawal. The more frequent of them are summarized in table 3. Gastrointestinal disturbances are due chiefly to gastritis and hypermotility, but they are sometimes complicated by cirrhosis, peptic ulcers and, not infrequently, pancreatitis. Cardiovascular symptoms sometimes become alarming to the patient and are presumably caused partially by sympathetic overactivity. The usual complaints encountered are palpitations and rapid pulse with a feeling that the heart is about to stop. Miscellaneous complaints include headaches, sweats, especially at night, and general tiredness.

In addition to the effects of withdrawal of a sedative drug, the physician treating the alcoholic must often deal with the problems of severe depletion of the body reserves of many essential elements. Through lack of food and poor general living habits, the alcoholic has often become seriously debilitated. It is essential that his nutritional balance be restored as rapidly as possible and that he be protected from complications, such as infections, while this restoration is being accomplished.

Perhaps the most vital step is adequate hydration and balancing of electrolytes. During a drinking spree the fluid intake is usually inadequate to meet body needs. Since mineral intake is also deficient, an electrolyte imbalance complicates the problem. The patient may be admitted with localized or general edema who is, in effect, dehydrated insofar as his intercellular water is concerned. The patient in alcohol withdrawal needs at least 3,000 cc. of water per day. During delirium tremens he probably needs twice this amount.

Electrolytes

Until electrolyte imbalances are corrected, supplying water serves little purpose. Although much work remains to be done concerning the nature and extent of the electrolyte disturbance, the following are frequently reported in the literature and are frequently seen in our experience:

1. Potassium levels are usually low. Correction of a deficiency here may be of vital importance to stabilize both heart and liver functions.

2.. Sodium levels are variable, but are frequently low. The patient usually seeks out salty foods on his own and correction is seldom difficult.

3. Magnesium is usually deficient. Reports on low serum levels are contradictory and inconclusive, but low spinal fluid levels are rather consistently reported in the literature. We almost routinely give magnesium sulfate intramuscularly if the patient's condition is poor, unless he is in a coma.

4. Calcium is frequently a little low, but rarely low enough to produce symptoms. Occasionally acute deficiencies with tetany occur.

5. A metabolic acidosis is frequent due to the accumulation of lactates, but is rarely severe.

Prevention or correction of vomiting greatly facilitates stabilizing the electrolyte systems and we routinely start an intoxicated patient on antiemetics usually of the meclizine hydrochloride (Bonine Hydrochloride) or dimenhydrinate (Dramamine) type on admission.

Vitamins

Mild to severe deficiencies in the B vitamins are the rule in alcoholics. There is some evidence that either the need for these is increased in alcoholics or the capacity to utilize them is decreased. In any case, the alcoholic seems to require much greater than average dosage of B complex. Deficiency symptoms almost typical of alcoholics include Wernicke's encephalopathy. This syndrome, which includes ataxia and nystagmus, often responds dramatically to even a single dose of thiamine. Peripheral neuritis is manifested by varying severities of numbness, paresthesia and at times paralysis involving one or many peripheral nerves. It also responds to thiamine, unless spinal cord damage is present, but much more slowly. Besides these, the classical deficiency diseases beriberi and rarely pellagra may still be seen among an alcoholic population.

The role of the B vitamins other than thiamine is much less clear. Nevertheless, deficiencies in nicotinic acid, riboflavin, pyridoxine and B_{12} have been incriminated in a variety of the problems of the withdrawal period and the patient seems to improve more rapidly when he is supplied with the entire B complex than when he is given thiamine alone. Occasionally in an alcoholic patient, usually one with cirrhosis of the liver, megaloblastic anemia develops and does not improve until folic acid is added to the regimen.

Protein

The problem of proteins has long plagued the physician working with alcoholics. The patient is usually already in negative nitrogen balance and physiologic functioning and tissue repair cannot begin until protein is supplied. Some degree of liver involvement, however, either transient or permanent, is present in the majority of patients at the time of sobering up. It has been conclusively demonstrated that the bulk of the fats which accumulate in the liver is transported there from the peripheral tissues and deposited there rather than being formed there. Nevertheless they do interfere with normal hepatic functioning including the ability to metabolize proteins. This situation leaves the clinician in a dilemma; he must supply protein yet the liver cannot metabolize it normally.

Various approaches to the problem have been tried such as starting with low protein diets and gradually increasing protein, giving normal diets until ammonia levels rise. During the last three years patients at the Florida Alcoholic Rehabilitation Center have been given a hydrolyzed protein product. This is ordinarily supplied orally; however, if there is marked enlargement of the liver or if the patient's condition is such that hepatic coma seems to be impending, intravenous arginine glutamate (Modumate) is given before the routine formula.

Additional Serious Complications and Precautions

These are a few potentially serious complications for which the physician should be alerted during withdrawal:

1. Congestive heart failure. This is difficult to diagnose at this time, as enlargement of the liver, dependent edema and chest rales are usually already present. It is important to diagnose

even mild failure, as congestion in the liver further compromises its already poor functioning. A persistently rapid pulse should arouse one's suspicions, and electrocardiographic findings and chest films should make diagnosis possible. Whether failure is due entirely to deficiencies in thiamine and potassium or whether an alcoholic myocardiopathy exists as a separate entity is being studied, but is not clear at this time.

2. It should also be mentioned that blood pressure tends to be elevated, but is unstable during the first 24 to 36 hours of withdrawal. During this period parenteral administration of phenothiazine drugs may cause severe hypotension and is potentially hazardous. Hydroxyzine (Vistaril) or chlordiazepoxide hydrochloride (Librium) is safer during the initial phase, but may be replaced by phenothiazine after 36 hours if indicated.

3. Hepatic coma may, of course, result in the course of advanced cirrhosis. It may, however, also occur without cirrhosis in alcoholics who have been on a heavy drinking spree, presumably because of the poor functioning of liver cells which are filled with fat. It is precipitated by absorption of nitrogenous materials from the intestinal tract, gastrointestinal hemorrhage, azotemia, deficiency of potassium, infection, rapid decrease of plasma volume, and certain drugs; ammonium compounds, chlorothiazide (Diuril), acetazolamide (Diamox) and morphine are among the chief offenders. Its onset may be suspected when a flapping tremor develops along with lethargy and confusion. It can often be controlled by giving neomycin or if due to kidney disease, oxytetracycline (Terramycin). Sometimes intravenous infusions of arginine or glutamate seem to be helpful. If the condition progresses to actual coma, protein must be eliminated from the diet.

4. Hemorrhage from esophageal varices occurs rather infrequently, but is an acute emergency when it does occur. It can sometimes be controlled by giving intravenous surgical pituitrin, 20 units in 200 cc. of glucose. If this fails, tamponade and surgical intervention must be attempted.

5. Infections, even minor ones, tend to become severe and to contribute to decompensation of the liver. If low grade fever and leukocytosis are present, the physician must look for an infectious process and treat it intensively.

6. There have been some reports of hypoglycemic reactions following drinking. These have sometimes proved fatal. The mechanism is not clear, but may be due to a vagally induced hyperinsulinism. There may also be occasional high blood sugar levels which normalize after drying out.

Suggested Withdrawal Routines

The aims of detoxication are (1) to restore the patient to a normal physiologic state as rapidly as possible, (2) to prevent the complications of withdrawal, and (3) to persuade the patient to seek treatment for the alcoholism. To accomplish the first of these objectives the patient must be supplied with the essential nutritional elements which he needs. They must be given quickly and in adequate amounts. To accomplish the second, some replacement for the alcohol withdrawal must be provided and this may be reduced gradually over a period of several days.

Suggested Detoxication Routine

Routines found helpful at the Alcoholic Rehabilitation Center are outlined and a brief comparison is presented of time spent on the hospital ward for patients receiving different medications during the drying-out period. Suggested routine for a patient who has been drinking as much as one fifth a day for five or more consecutive days:

To Calm Agitation

Tranquilizer:	Hydroxyzine, 100 mg. routinely every four to six hours while awake—taper as tolerated
Sedative:	For the first three or four nights (second and third are especially important)

To Supply Nutritional Needs

Amino acids (We use a hydrolyzed milk product 97% free amino acid)	10 Gm. four times a day orally in fruit juice for three to four days
Magnesium sulfate	2 cc. of 50% solution intramuscularly twice a day for two to three days
Potassium chloride	2 Gm./day in enteric-coated tablets for three to five days
Juices	As much as tolerated—total fluid intake 2,000 to 3,000 cc.
B complex	2 cc. intramuscularly for five days; then tablets three times a day; in some instances sodium and calcium must be supplied in addition to the amounts in the diet

To Modify or Prevent Complications

Meclizine hydrochloride, or other antiemetic as necessary, orally, rectally or intramuscularly for one to three days
Methocarbamol (Robaxin) or chlormezanone (Trancopal), or other muscle relaxant, orally four times a day for four to five days as needed to modify tremor
Anticonvulsant for 14 days to prevent seizures

If other problems develop, they are treated as they arise. If the patient's condition is poor with marked dehydration, marked swelling of the liver and evidence of recent injury or of severe infection, we usually start treatment with intravenous fluids using (1) Ringer's lactate; (2) Aminosol in glucose or arginine glutamate in glucose; and (3) 10% glucose in water with 10 cc. of B complex.

If the patient is restless and anxious or is confused toward the end of the second or third day, switch from the tranquilizer in use to a phenothiazine or sedative and attempt to insure sleep during that night.

If the reflexes are decidedly hyperactive and the patient overirritable on admission, we often give a single intramuscular dose of barbiturate. Such patients often convulse.

Summary

Alcoholism is an illness which produces profound but still poorly understood changes in the patient. Recent studies indicate disturbances in the metabolism of carbohydrates, fat, proteins and probably also the catecholamines. These are added to the effects of withdrawal of a depressant drug to which the patient has become habituated. In addition, some degree of malnutrition is usual.

The severity of an alcohol withdrawal reaction may often be anticipated by considering the age of the patient, his drinking history, general health, and concomitant use of other drugs.

A withdrawal reaction is typically disabling for three to five days and may present serious complications.

Careful attention to fluid and nutritional needs, together with substitution of sedative or ataractic drugs for alcohol will shorten the period of disability and aid in prevention of many complications.

Close observation and early treatment will decrease mortality from the serious complications which develop.

References are available from the author upon request.

Dr. Williams, P.O. Box 1147, Avon Park 33825.



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More than 110,000 persons are now wearing the Medic Alert Emblem. Distributed by the Medic Alert Foundation International, it carries on one side the Staff of Aesculapius and the words "Medic Alert" in red, while on the reverse side is engraved the immediate medical problem. Information and membership application forms may be secured by addressing Medic Alert Foundation, Turlock, California 95380.

The Influence of Dipyridamole (Persantin) and Nitroglycerin on Coronary Blood Flow

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Lamar Crevasse, M.D.,**
Thomas Bartley, M.D.,†
J. C. Shipp, M.D.‡

Since the discovery of nitroglycerin one hundred years ago, interest in the effect and mechanisms of action of various drugs upon the coronary circulation has been high. Although speculation as to mode of action of such drugs as nitroglycerin has been increasing, little firm evidence supporting such speculations exists. Anyone, however, who reviews the literature concerning the effects of nitroglycerin on the circulation is left in a state of confusion regarding the fundamental question: Does nitroglycerin increase coronary blood flow per se without first altering other hemodynamic parameters? The mechanism of action remains a mystery. For example, cardiac output, coronary blood flow, ventricular work, and myocardial efficiency have all been reported to be increased, decreased, or unchanged by nitroglycerin.[1-10] When one considers all these observations and keeps in mind that nitroglycerin produces what has been called a rapidly fluctuating, unsteady state,[11] the paradoxical results of these investigations begin to have more meaning. The physiologic state of the animal at the time of measurement is the paramount consideration in evaluating the effects of the drug. The present study is a comparison, in an exceptionally stable experimental model, of the action of nitroglycerin with that of dipyridamole (Persantin), a pyrimido-pyrimidine which has been previously demonstrated to enhance markedly coronary blood flow.[12]

Experimental Method

In the dog, 95% of the total venous return enters the right heart via the coronary sinus and anterior cardiac veins.[13,14] This route allows the separation of coronary return from the rest of the venous return utilizing the complete right heart bypass preparation as described by Elliott[14] (fig. 1). Blood flow from both venae cavae is diverted

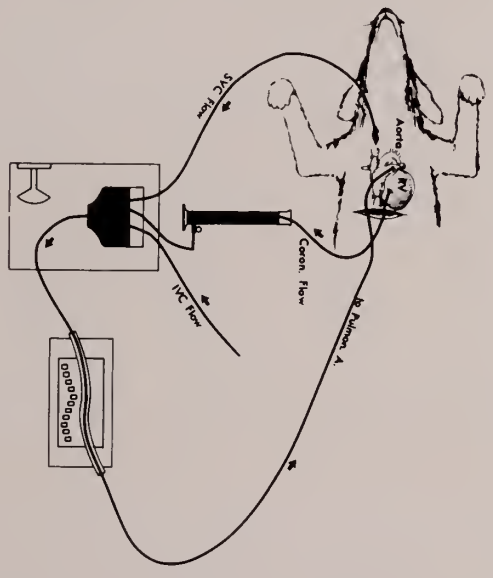


Fig. 1.—Isolated Right Heart Perfusion System The venous blood from the superior vena cava (SVC) and inferior vena cava (IVC) is returned to a central reservoir, and then pumped via a sigma motor pump at a controlled output into the isolated pulmonary artery. The coronary return from the right ventricle is measured directly into a graduated glass cylinder. Adequate ventilation and arterial oxygen saturation are maintained by a Harvard respirator (after Elliot).

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Supported by a grant from the Florida Heart Association.

into a venous reservoir from which blood is pumped back into the pulmonary artery via a sigma motor pump under controlled flow conditions. Seely, Nerlisk, and Gregg[15] have shown that known amounts of blood pumped into the pulmonary arteries correlate well with the estimated cardiac output. By occluding the pulmonary artery with tape to prevent regurgitation and having a catheter inserted into the right ventricular chamber, all the coronary blood returning to the right heart will be directed into a small reservoir. The catheter can, in turn, be directed from the reservoir to a collection container, a 100 ml. graduated cylinder and flow determined per unit time.

Five dogs were used having a range of weight of 10.0 Kg. to 22 Kg. (average 15 Kg.). Dogs were anesthetized with 30 mg. per Kg. of sodium pentothal. Prior to insertion of the major catheters, the dogs were given 2 mg. per Kg. of heparin. Cardiac cannulations were performed via a right thoracotomy. During the open chest period the dogs received 100% oxygen with the aid of a mechanical respirator attached to an endotracheal cuff tube. The electrocautery was used throughout the entire surgical procedure to minimize bleeding. Before cannulations were attempted, it was thought that blood pressure should be at least 140/90 mm. Hg. When the cannulations were completed, the bypass was started by removing the clamps on the caval catheters which had been placed in the cava via the left external jugular and right femoral veins. Simultaneously, the clamp from the pulmonary artery connection was removed and the sigma motor pump was started. The transition was accomplished smoothly and with no difficulty.

We have found that several parameters can affect the stability of the preparation. Hyperventilation and hypoventilation can result in marked variations of blood pressure and coronary flow. Blood oxygen concentration varies remarkably with each animal with any given respiratory rate. Prior, therefore, to insertion of catheters and each experimental period, hemoglobin saturation was measured and the procedures not started unless arterial blood oxygen saturation was greater than 90%. Because of the magnitude of the surgical procedure, blood pressure in the healthiest dogs uniformly decreased on the pump. No data were considered acceptable unless systolic blood pressure was greater than 100 mm. Hg.

Cardiac output, coronary blood flow and oxygen consumption were measured. Cardiac output could be fixed or varied. When using dipyridamole in a concentration of 0.3 mg. per Kg. or nitroglycerin in a concentration of 0.01 mg. per Kg., but never greater than 0.1 mg. total dose, the output was fixed at a rate calculated as 100 cc. Kg./min. Coronary A-V oxygen difference was measured by the Hickam-Fraysier method.[16] Arterial pressure was recorded by a Grass recorder.

Results

Figure 2 illustrates the effects of varying cardiac output upon coronary blood flow, oxygen extraction and myocardial efficiency. In this experiment, cardiac output was gradually increased from 200 ml./min. to 1,800 ml./min. At low cardiac outputs (up to 1,000 ml./min.), coronary flow was relatively fixed. The low level of oxy-

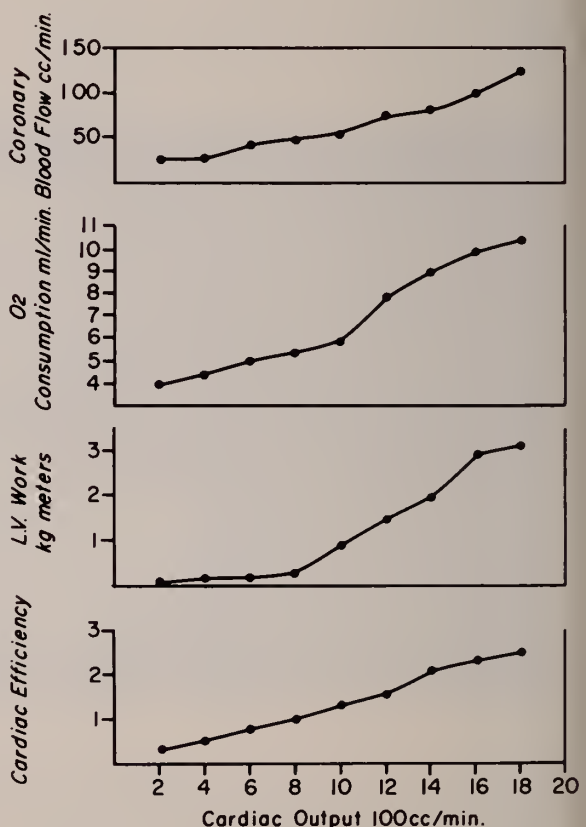


Fig. 2.—Cardiac output was increased in 200 cc. increments over the range of 200 to 1,800 cc. Coronary flow, oxygen consumption, left ventricular work and cardiac efficiency were determined for each output.

gen consumption below 1,000 ml./min. may be a reflection of anaerobic metabolism. This is supported by the absent cardiac work and extremely low cardiac efficiency. When, however, cardiac output was increased above 1,000 ml./min., there was an almost straight line proportional increase in all parameters, being most apparent in cardiac work and oxygen consumption.

If one calculates the percentage of cardiac output represented by coronary flow, it is seen that at low flow rates 20% of the cardiac output is traversing the coronary vascular tree whereas, with a cardiac output of 1,000 cc. or greater, the percentage of blood represented by coronary flow represents about 7%. With a very low cardiac output, the blood pressure of the animal is severely depressed. Hence, the large percentage of cardiac output represented by coronary flow reflects the intense coronary vasodilatation which occurs with hypoxia secondary to a low cardiac output. The sharp rise in oxygen consumption accompanying an increase in cardiac output from 1,000 to 1,200 cc./min. with a more gradual increase after 1,200 cc./min. cardiac output in all likelihood represents an accumulated oxygen debt.

Figures 3 and 4 demonstrate the effects of nitroglycerin and dipyridamole on coronary blood flow with a fixed cardiac output of 1,000 cc./min. Both drugs induced a transient decrease in systolic and diastolic blood pressure. The onset of this effect was more gradual with dipyridamole but quite abrupt with nitroglycerin. Note that nitroglycerin in this preparation caused a decrease in coronary blood flow and this correlated well with the decrease in blood pressure. Dipyridamole gave an immediate and prolonged increase in coronary blood flow despite the small decrease in blood flow and narrowing of the A-V oxygen differ- in this preparation is similar to that reported by others with respect to an increase in coronary blood flow and narrowing of the A-V oxygen difference.[14,17,18] Nitroglycerin had no effect on A-V oxygen difference.

Figure 5 illustrates the mean ± S.E. of the coronary flow determinations in the total group of animals studied and correlates coronary blood flow with oxygen consumption, left ventricular work and coronary resistance.

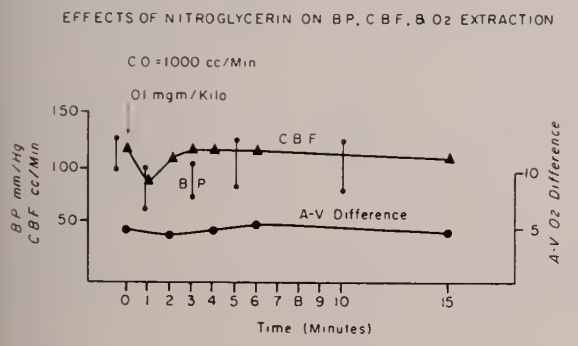


Fig. 3.—Nitroglycerin, 0.01 mg./Kg., was injected at time zero into the pulmonary artery and blood pressure (B.P. = :), coronary blood flow (C.B.F. = Δ), and coronary arteriovenous oxygen difference (A-VO_2 difference = •) were followed at intervals for 15 minutes. Cardiac output (C.O.) was fixed at 1,000 cc./min.

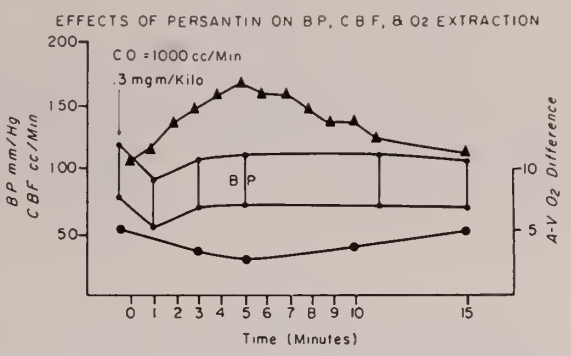


Fig. 4.—Dipyridamole, 0.3 mg./Kg., was injected at time zero into the pulmonary artery and blood pressure (:), coronary blood flow (Δ), and coronary arterial venous oxygen difference (•) were measured at intervals for 15 minutes. Cardiac output (C.O.) was fixed at 1,000 cc./min.

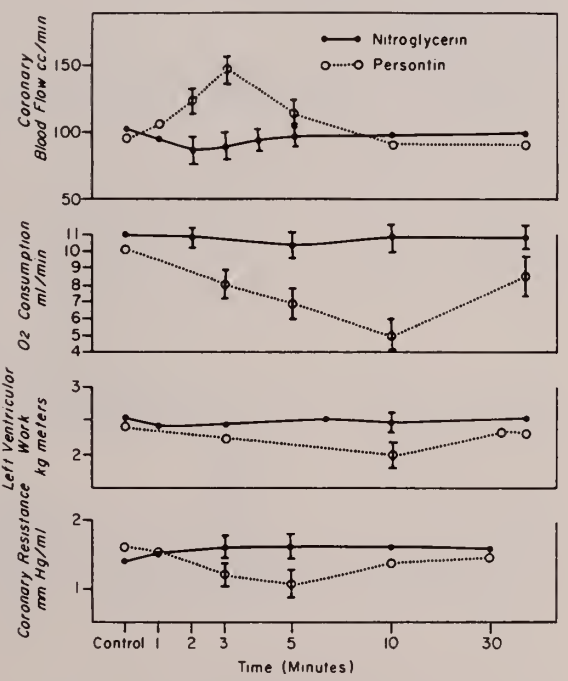


Fig. 5.—The effects of nitroglycerin and dipyridamole on coronary blood flow, myocardial oxygen consumption, left ventricular work and coronary resistance are contrasted (:) ± S.E.

Nitroglycerin in general had little effect on left ventricular work, coronary resistance and oxygen consumption. Dipyridamole remarkably decreased oxygen consumption, had a small but significant effect on decreasing left ventricular work and significantly decreased coronary resistance.

Discussion

Previous workers have been unable to come to any major agreement as to the action of nitroglycerin on coronary blood flow because of the rapidly changing, unsteady state induced by the drug. These rapid and wide fluctuations in cardiac output and arterial saturation induced by nitroglycerin have contributed to the dilemma of properly evaluating whether nitroglycerin increases coronary blood flow independent of other parameters. In the highly controlled experimental model employed here, cardiac output, oxygen saturation, and venous return were completely controlled. Although nitroglycerin had a profound effect on peripheral vascular resistance with a transient decrease in blood pressure, there was no increase in coronary blood flow. In contrast, dipyridamole diminished peripheral vascular resistance to a lesser degree than nitroglycerin but induced a substantial and prolonged increase in coronary blood flow.

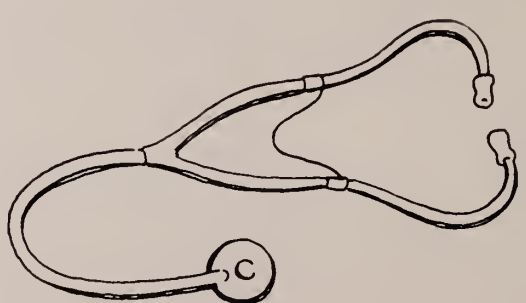
Clinically there is little doubt as to the efficacy of nitroglycerin in the majority of persons with angina pectoris. Although responsible for the relief of symptoms in some patients, dipyridamole has not demonstrated this widespread effectiveness associated with nitroglycerin. While extrapolation of animal data is hazardous, the major hemodynamic action of nitroglycerin seems to be one of acutely reducing peripheral vascular resistance. These observations on nitroglycerin in a highly controlled experimental model are consistent with the finding of Gorlin, Brachfeld, MacLeod, and Bopp[19] that coronary blood flow did not increase, and occasionally decreased, after nitroglycerin in patients with coronary artery disease.

Summary

The effects of nitroglycerin and dipyridamole on coronary blood flow have been studied in a highly controlled experimental model in dogs. Both drugs induced a transient decrease in blood pressure. Dipyridamole gave an immediate and prolonged increase in coronary flow while nitroglycerin produced a transient decrease in coronary flow. Nitroglycerin had little effect on left ventricular work, coronary resistance, or myocardial oxygen consumption while dipyridamole decreased oxygen consumption and coronary resistance. The major hemodynamic action of nitroglycerin was in reducing peripheral vascular resistance without increasing coronary blood flow.

References are available from the authors upon request.

Drs. Tubbs, Crevasse, Bartley and Shipp; College of Medicine, University of Florida, Gainesville 32603





President's Page

"Heart Disease, Cancer, and Stroke"

Degenerative vascular disease and cancer are the principal causes of death in this country. Pneumonia and other infectious diseases have taken a back seat thanks to the antibiotics. Accidents, especially automobile, are rapidly advancing to the head of the list, especially for those in the "executive years."

A reduction in the incidence of heart disease, cancer, and stroke as the causes of death was the stated objective of Public Law 89-239 enacted by Congress in 1965. A macabre wag was heard to remark, "That's easy—just build more automobiles."

The original proposal to Congress would have created 500 regional medical complexes regionalized about medical schools and employing physicians to diagnose and treat heart disease, cancer, stroke and other major related diseases.

Fortunately the bill was amended in Congress. The original title with amendments indicated by the lined words, was as follows:

~~REGIONAL~~ ~~MEDICAL~~ ~~COMPLEXES~~ ~~FOR~~ ~~RESEARCH~~ ~~AND~~ ~~TREATMENT~~ ~~IN~~ EDUCATION, RESEARCH, TRAINING, AND DEMONSTRATIONS IN THE FIELDS OF HEART DISEASE, CANCER, STROKE, AND ~~OTHER~~ ~~MAJOR~~ RELATED DISEASES.

The present law, therefore, is directed to the support of education, research, and demonstration projects in the fields of Heart Disease, Cancer and Stroke with the primary objective of improving communications of medical knowledge.

The Florida Medical Association took the initiative to form a Florida Advisory Council on Heart Disease, Cancer and Stroke under the provisions of Public Law 89-239. This advisory council has official representatives from the Florida Medical Association, State Board of Regents, University of Florida College of Medicine, University of Miami School of Medicine, University of South Florida, Board of Trustees of the University of Miami, Florida Hospital Association, Florida State Board of Health, Florida Division, American Cancer Society and Florida Heart Association.

The Council has requested a grant for feasibility studies and planning to:

1. Encourage the development of regional cooperative programs.
2. Study the means of coordinating the many medical education, research and training programs throughout the state.
3. Develop guidelines for regional programs in Florida.

The Florida Medical Foundation has been named fiscal agent for the study grant. The opportunity for practicing physicians in Florida to cooperate with educational institutions in improving continuing medical education throughout the state should be fully developed.

H. Phillip Hampton



Hints to Authors

It is that time of the year again. With the spring meetings of state associations and specialty societies approaching, thoughts of the essayists turn to the preparation of their papers. Physicians probably write more papers than members

See following editorial

of almost any other profession and frequently with some trepidation so far as preparing the manuscript for publication is concerned. They seem at a loss to know how to proceed.

The successful author makes sure at the outset that he has something worth saying and his second goal is to say it properly. He selects a subject in the field with which he is most familiar and prepares an orderly, systematic, scientific outline as a guide to logical presentation. He plans his article in keeping with the usual pattern followed by the publication to which he will submit it.

The best writing is in the author's natural style, with due regard for essential refinements. It has been well said that style in writing is much the same thing as good manners in other human intercourse. Probably the medical editor and the medical educator alone realize fully the apparent ignorance of English grammar, of good usage, and of the meaning of words among the medical profession. Brevity, a cardinal virtue, is unfortunately never easy to achieve. Vigorous writing is concise and to the point. Clarity is promoted by the use of carefully chosen words and short sentences. Simplicity, like brevity, is elusive, but tremendously rewarding when attained. Skillful paragraphing and liberal use of interesting and provocative subtitles also help the reader.

Extensive reviews of the literature are no longer acceptable. References are to be held to a minimum. Jargon and fancy words are to be scrupulously avoided. Choose illustrations that illustrate. They are intended to augment the text —not to be repetitious.

The medical society address is much too frequently written for reading and then submitted for publication without revision. Once the material is coordinated for presentation, revise and revise and revise again—maybe five or six times or more. Even then, if the article is accepted, be prepared for the technical editor's red pencil. It is the unusual author indeed whose manuscript escapes it.

The familiar maxim still holds good—a manuscript that is fit to read is sometimes fit to print, but a manuscript that is fit to print is always fit to read.

Edith B. Hill
Editorial Consultant for The Journal
Jacksonville

A Gentle Contribution

In 1940, the editorial appearance of The Journal of the Florida Medical Association began a new era, with the very noticeable addition of a gentle constant grammatical style, properly punctuated. To achieve these ends and yet maintain the original thought and manner of expression that is characteristic of each author was then and has been the goal of Mrs. Edith B. Hill, Editorial Consultant for The Journal of the Florida Medical Association. Through the years all published information has profited from her study, and many members of our Association, with her guidance, have become better writers and speakers.

The preceding editorial was written by Mrs. Hill. Many times she has performed this chore for others, but now, unknown to our Consultant, her work will carry her signature for each to see and so to know the part she has played in all our editorial efforts. Through three executive directors, several managing editors and three editors, her precise thinking and knowledgeable editorial manner have served The Journal, always seeking to improve the material presented and the written word used in each presentation.

As I have in the past and do continue to serve my apprenticeship to your Journal, I am each year more aware of the significant contribution Mrs. Hill has made to the medical education of each FMA member and to the writing skills of many FMA members.

We are fortunate to have her with us, for her knowledge and interest have created our present Journal image. Mrs. Hill has seen to this!

T. M.

Diabetes Detection and the FBS

Diabetes mellitus is an inherited disorder manifest by metabolic and nonmetabolic features. Vascular disease is an accepted part of the diabetic syndrome, not merely a complication. There is a generalized disturbance of metabolism involving carbohydrates, lipids and protein. At present, however, diagnosis rests on the demonstration of impaired glucose tolerance.

Over 80% of adults with detectable diabetes do not manifest fasting hyperglycemia and will be missed if screened by the FBS. It is the adult who is asymptomatic, or who presents with vascular or other manifestations of diabetes, that most screening attempts are designed to detect.

What simple approach to detection can be applied to an office, or hospital setting, and be both specific and sensitive? First, the yield from screening tests will be much greater if particular attention is given to those most likely to be diabetic. About 20% of patients with a family history of diabetes, or a history of stigmata of diabetes (birth weights over 10 pounds, frequent spontaneous abortions or still births, reactive hypoglycemia, vascular disease at an early age, and glycosuria or hyperglycemia during pregnancy, surgery, infection, strokes, myocardial infarction or with any acute illness) can be shown to be diabetic. In the general adult population about 4% are diabetic.

Existing empirical criteria for normal glucose tolerance are applicable to patients who are active and who have eaten a diet unrestricted in carbohydrate for the preceding three days, or longer. A diet containing 200 Gm., or more, of carbohydrate daily is adequate.

Blood specimens to detect impaired glucose tolerance should be done, *not fasting,* but after a glucose load. This can be done with a known amount of dextrose and there is little difference in the glucose tolerance curves with either 75 or 100 Gm. of dextrose orally. Certain patients tolerate the commonly used pint of sugar water poorly; prolonged ingestion, vomiting, or delayed gastric emptying may make interpretation of results difficult. To obviate this problem, especially frequent in females, one may use certain available preparations prepared in smaller volume with a cola taste, or, more simply, ask the patient to eat a meal containing approximately 100 Gm. of carbohydrate at a specified time prior to obtaining the test sample. For example, a palatable breakfast of 4 slices of toast with 3 tablespoonfuls of jelly will contain close to 100 Gm. of carbohydrate. Coffee, tea and cigarettes should be omitted.

The blood glucose concentration two hours after 75 to 100 Gm. of glucose, or carbohydrate, has been established as a specific and fairly sensitive screening test. A one hour value may be used; this is probably more sensitive but is less specific than the two hour value, and false positives will be encountered. Thus, if screening is to be by one blood glucose determination it should be the two hour value.

Abnormal responses on the single test screening should be further evaluated with a three to five hour glucose tolerance test, a recommended primary approach in the high suspect group. This more complete information reduces the problems inherent in interpreting a single value which is subject to error in performing the test, and in the

laboratory. From the glucose tolerance test one can determine an abnormally high peak concentration of glucose at one hour, a delayed return to normoglycemia at two to three hours, and possible hypoglycemia in the three to five hour period—all features of diabetes.

Based on true glucose values, a blood glucose concentration over 120 mg./100 ml. two hours after ingestion of 75 to 100 Gm. of glucose is abnormal. At one hour the value should not exceed 160 mg./100 ml. If either value is exceeded, a glucose tolerance test is indicated. The Folin-Wu method for glucose does not measure true glucose and values are about 20 mg./100 ml. higher; optimally the Folin-Wu method should not be used. Also, the recently introduced Dextrostix method is not sufficiently accurate to detect mild degrees of glucose intolerance.

Diagnosis of diabetes is important so that treatment with diet, and in some instances oral hypoglycemic agents, can be started early. Education of the patient may prevent or lead to early treatment of serious complications such as ketoacidosis, vulvovaginitis, infections of the urinary tract and elsewhere, and foot lesions. Weight control, which will restore carbohydrate utilization to or toward normal, is of particular importance. Recent observations show that the sulfonylurea drugs, such as chlorpropamide and tolbutamide, improve glucose tolerance and, indeed, may prevent the appearance of the overt diabetic state.

Joseph C. Shipp, M.D.
GAINESVILLE

Intestinal Parasitic Infestation

The paper "Intestinal Parasitism in South Florida" by Drs. Beck and Farrer appearing in this issue of The Journal is especially welcomed. In these modern days of "shoes," attention to environmental sanitation and emphasis on personal hygiene, we physicians tend to belittle the role of intestinal parasitism in human discomfort and disease. Certainly, the parasites are not at all a condition of the more crude yesteryears, but continue shockingly present even today. Drs. Beck and Farrer report an overall "positive rate" of almost 30 per cent and point out, with supporting data, that had all patients been examined adequately, the number of positives would have been even greater. Hopefully, the efforts of these authors will refocus our attention to and concern for these treatable, yet preventable conditions.

Their point is well taken that in South Florida almost any patient is a suspect for parasitic infestation. They suggest that certain socioeconomic groups are at particular risk. We wonder, however, whether or not their conclusions as to infestation rates by socioeconomic class were really justifiable. The assumption was made apparently that all persons admitted to Jackson Memorial Hospital, or at least those examined for intestinal parasites, belong to the lower socioeconomic groups. In view of the large private diagnostic practice centered there, such an assumption seems invalid. Further, the authors seemingly assumed that the persons examined by the public health laboratory in Miami also belonged to a lower socioeconomic group. Surely, this assumption is also invalid. Without appropriate supporting data there seems to be no justification for the statement that the high rates of parasites among the Seminoles (lower socioeconomic class) significantly influenced the findings at the regional laboratory.

See scientific article page 194

It is generally known that children have higher rates of intestinal parasites than do adults of equal class. Further, children are more likely to be examined for parasites than are adults. Such is certainly true in the public health clinics and stool examinations are "routine" for all admissions to the Pediatric Services of Jackson Memorial Hospital, social class notwithstanding. The authors state that their index study involved adults predominantly. Could not differences in parasite rates by age also explain the variations noted by Drs. Beck and Farrer in the number of positives by laboratory?

Since the paper in the first paragraph purported to address the question of importation of tropical parasitic diseases into the South Florida area, we were a little disappointed that the report failed to make appropriate comparison between the parasites of the Caribbean islands and Latin America and the findings of the present study. Indeed, there even was no mention of positive findings in the about 100 patients giving a history of having been outside the continental United States. Certainly, though, the traveler into the Caribbean and Latin America does carry increased risk for acquisition of an intestinal parasite.

In spite of the several criticisms concerning the analytic attitude of the report, the data of the paper are well received and appreciated. The common, old fashioned, unpopular "worms" are still with us. May we never become complacent about them.

E. Charlton Prather, M.D., Director
Division of Epidemiology
Florida State Board of Health
Jacksonville

PLAN TO ATTEND

92nd Annual Meeting, May 12-15

Diplomat Hotel, Hollywood Beach



normal activity...

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In children with diarrhea prompt symptomatic control is usually urgently indicated to relieve cramping and to prevent dehydration.

Lomotil halts precipitous progress through the intestines and controls diarrhea with notable promptness, safety and effectiveness.

Experimental evidence[1] has shown that Lomotil is more efficient in this regard than morphine without the latter's manifest disadvantages. In roentgenographic study[2] Lomotil slowed gastrointestinal propulsion within two hours.

At the same time, by diminishing overstimulation of the intestines, Lomotil relieves the abdominal cramps and discomfort so distressing to youngsters.

Lomotil gets children off toast and tea and back to normal diets and normal activity with gratifying celerity.

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Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: may be habit forming)
atropine sulfate ..... 0.025 mg.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial *daily dosages,* given in divided doses, until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one fourth the therapeutic dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholinobutyryl-pyrrolidine and Related Amides. Part 1: Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.

2. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.

SEARLE

Research in the Service of Medicine



Government News

PL 89-74

Editor's Note: The following information comes to the Florida Medical Association through the courtesy of C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, 1155 15th Street N. W., Washington, D. C.

Illicit drug traffic is a serious matter. Legislation controlling the handling of drugs has an impact that is felt throughout the medical profession. Such legislation often creates doubt and confusion among physicians as to how they are specifically affected and what requirements are demanded of them in complying with the law.

The editorial staff of The Journal is indebted to Mr. Stetler for the timely information he has furnished clarifying the law concerning the handling of drugs.

Mr. Stetler has formerly served as general legal counsel to the American Medical Association.

T. M.

On February 1, 1966, PL 89-74 went into effect. As has been widely publicized, its purpose is to curb drug abuse through the curtailment of illicit drug traffic. To accomplish this, the law establishes special controls over the manufacture and distribution of depressant and stimulant drugs. Among these controls is the keeping of records of the manufacture, sale, delivery, and receipt of such drugs, and it is to this matter of record-keeping, insofar as it refers to physicians, that I would like to invite your attention.

Recently, there has been some confusion as to what records a physician must keep under PL 89-74. Putting it simply, *they are not required to keep records as a consequence of this law unless, in the course of their practice, they dispense the drugs referred to and charge for them.* The law is quite clear on this, and I quote from that part of the Act relating to record-keeping:

> "The provisions of paragraphs (1, Records) and (2, Inspection) of this subsection shall not apply to a licensed practitioner . . . with respect to any depressant or stimulant drug received, prepared, processed, administered, or dispensed by him in the course of his professional practice, unless such practitioner regularly engaged in dispensing any such drug or drugs to his patients for which they are charged, either separately or together with charges for other professional services."

The key phrases in this paragraph are the words "regularly engaged" and "for which they are charged."

Further in this regard is a quote from the House Report of the Committee on Interstate and Foreign Commerce on H.R. 2 which became PL 89-74:

> "The committee intends . . . to require record keeping and to permit inspection in the case of those physicians who maintain a supply of pharmaceuticals or medicinals in their offices from which they compound prescriptions for their patients for a fee."

The language of the Senate Committee Report is identical. Both committee reports stated that those required to keep records "involve only a very small percentage of physicians."

The proposed regulations underscore this point, indicating that ". . . maintaining of small supplies of these drugs for dispensing or administering in the course of professional practice in emergency or special situations will not be considered as regularly engaged in dispensing for a fee."

For those physicians who, in the course of their practice, *regularly dispense drugs and charge for them,* certain records are required to be kept for three years, effective February 1, 1966. Included are: (1) a complete, accurate record of all depressant and stimulant drugs on hand February 1, 1966; (2) a complete, accurate record of the kind and quantity of each drug received, sold, delivered or otherwise disposed of; (3) the name, address (and registration number under Section 510 (e) of FDCA) of the person from whom the drugs were received, and to whom they were sold, delivered, dispensed or otherwise disposed of; (4) the date of the transaction. No separate form for these records will be required as long as the information specified is available.

Summing up, under PL 89-74 physicians do not have to keep records unless they regularly dispense the drugs covered by the Act and charge for them.

Drug Solicitation for Charity

Drugs and medical devices collected for distribution through charitable channels must fully comply with the provisions of the federal Food, Drug and Cosmetic Act, according to recent communication from the U.S. Food and Drug Administration.

The FDA states that physicians' samples are intended for physicians and should be used by them in their professional practice.

In a letter to the State Board of Health concerning the collection of drugs by an organization for redistribution abroad through charitable channels, the FDA states that such collection of drugs and/or medical devices is considered improper.

The FDA did add, however, that should it be possible to work out a procedure whereby suitable sample drugs are transferred intact from one physician directly to another abroad in their original containers, such a procedure would offer the proper safeguards to assure the purity and potency of the contents.

Medicare Reimbursement For Hospital-Based Physicians

Recently the Social Security Administration released a set of "guides" titled Reimbursement Under Medicare for Services of Hospital-Based Physicians." The guides contain eight principles which are intended to be the basis for regulations soon expected.

The eight principles were proposed by the SSA, approved with some modification by the Health Insurance Benefits Advisory Council, and then redrafted and released by the SSA.

In essence, the eight principles are as follows:

(1) Health insurance programs are not to determine compensation arrangements between a hospital and a hospital-based physician.

(2) Medical and surgical services rendered to a covered individual by a hospital-based physician are reimbursed only under the supplementary insurance program. Hospital costs for non-professonal services by a physician to a patient will be included in the reasonable cost reimbursement under the hospital insurance program.

(3) A professional service reimbursable only under the medical insurance program is defined as a service requiring personal performance by a physician which contributes to the diagnosis or treatment of the patient to be charged under the medical insurance program.

(4) For reimbursement, the Government will respect, within reasonable limits, an agreement between hospital and physician concerning apportionments of the physicians compensation between individual patient care and institutional service. Upon failure of agreement, or unreasonable agreement, the issue will be resolved by the fiscal intermediary handling payments under the hospital program or the carrier handling payments under the medical program.

(5) Upon determination of the portion of the physician's compensation attributable to professional services to medical insurance beneficiaries, a schedule of charges can be developed. Reasonable charges should be designed to yield the physician an aggregate equal to his compensation portion. The charges may be based on a schedule of relative values, a uniform percentage of similar charges made to other patients, or any other method approved as equitable by the carrier.

(6) Where a hospital-based physician bears some or all hospital department operational costs and bills his patients directly rather than through the hospital, the reasonable charges for his services under the medical program will reflect the costs he bears. Where the physician bears all the costs, charges previously agreed upon between

the hospital and physician for such services may be accepted as reasonable for the medical program, but they will require adjustment if the hospital has been bearing a cost significantly greater or less than its share of the proceeds under such an agreement.

(7) Hospitals and hospital-based physicians will be required to keep records substantiating agreements they enter into concerning the physician's compensation.

(8) Nothing in the foregoing principles restricts the physician's right to determine the amount charged the patient for his services, or restricts the hospital and the physician from making an agreement as to the disposition of payments received under the programs.

The Health Insurance Benefits Advisory Council is a 16 member group appointed by the Secretary of Health, Education and Welfare to help the Government shape policies for the administration of the Medicare program.

Members of the council include persons nationally prominent in the fields of medicine, hospital care, nursing, nursing homes, business, labor and insurance. The members of the HIBAC are:

Kermit Gordon (Chairman), vice president, Brookings Institution.

William E. Beaumont, Jr., president emeritus, American Nursing Home Association.

Bernard Bucove, M.D., director, Washington State Health Department.

Kenneth W. Clement, M.D., past president, National Medical Association.

Dorothy A. Cornelius, R.N., executive director, Ohio State Nurses' Association.

Nelson H. Cruikshank, former director, Department of Social Security, AFL-CIO.

C. Manton Eddy, president, Health Insurance Association of America.

Caldwell B. Esselstyn, M.D., executive director, Community Health Association, Detroit, Michigan.

Jose A. Garcia, M.D., practicing physician, Corpus Christi, Texas.

The Very Rev. Msgr. Harrold A. Murray, director, Bureau of Health and Hospitals, National Catholic Welfare Conference.

Russell A. Nelson, M.D., president, The Johns Hopkins Hospital, Baltimore, Maryland.

Howard P. Rome, M.D., president, American Psychiatric Association.

Samuel R. Sherman, M.D., chairman, AMA Council on Legislative Activities and Council on Economics of Medical Care.

Nathan J. Stark, president, Kansas City General Hospital and Medical Center Corporation.

Ray E. Trussell, M.D., director, Columbia University School of Public Health and Administrative Medicine.

Carroll L. Witten, M.D., president-elect, American Academy of General Practice.



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Each gram contains:

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Tubes of ½ oz. and 1 oz.

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For the eradication of infectious organisms in a wide range of dermatologic disorders: impetigo, ecthyma, pyodermas, sycosis vulgaris, paronychia, traumatic lesions, eczema, herpes and seborrheic dermatitis. Prophylactically, for protection against bacterial contamination in burns, skin grafts, incisions and other clean lesions, abrasions and minor cuts and wounds.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Contraindication: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Complete literature available on request from Professional Services Dept. PML.

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chronic fatigue—lethargy





stent insomnia



when emotionally based complaints fit the symptom profile of depression



severe anorexia—weight loss

recurrent G.I. upset

ical Considerations: **Contraindications**—Glaucoma, urinary retention, bone marrow depression, pregnancy, drug-induced CNS depression. **Precautions**—The sam
e for the two components, perphenazine and amitriptyline. Use carefully in patients with histories of convulsive disorders or adverse reactions to phenothiazines. ETRA
ntiates effects of antidepressants, CNS depressants, atropine, phosphorous insecticides, and heat. The antiemetic effect of the perphenazine component may con
ence of brain tumor, intestinal obstruction, or toxicity due to overdosage of other drugs. Consider the possibility of potentiation in combined use with MAOI drugs. (
y allow two weeks between therapies. Not recommended for use in children. **Warning:** Patients who become drowsy with ETRAFON should be cautioned against drivi
r operating machines requiring alert attention. Response to alcohol may be potentiated. **Side Effects**—Similar to those reported following the use of either compo
n used alone. For perphenazine alone, side effects caused by any of the phenothiazines may occur. These include extrapyramidal symptoms, autonomic react
uding hypertension), blood dyscrasias, liver damage, endocrine disturbances, allergic reactions, peripheral and cerebral edema, reversed epinephrine effect, grand
ulsions, polyphagia, reactivation of psychotic processes. For amitriptyline alone, drowsiness, hypotension, numbness and tingling of extremities, transient confusion
dosages), activation of latent schizophrenia (although perphenazine in ETRAFON may prevent this reaction in some cases). Dose-related anticholinergic reactions are
. Rare appearance of agranulocytosis, jaundice, and peripheral neuropathy, all possibly of drug origin, have been reported in patients receiving amitriptyline. For n
plete details, consult Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07
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Scher

new Etrafon helps restore the appetite for life



n the patient's symptom pattern and the absence of physical findings confirm your suspicion of a depressive state, ETRAFON
ly reverse the mental and functional slowdown—and allay the anxiety that accompanies depression. *"...it is rare to find a depres*
nt who does not also present definite symptoms of anxiety."[1]

ıpt symptomatic response: Somatic and ional target symptoms are reported to ɔnd promptly.[2-4] Insomnia, often the important complaint in depression, is first to be relieved.[2] (Bowes[5] found that ransient drowsiness sometimes caused TRAFON was generally beneficial to nts.)

ON *offers the flexibility and convenience of 2 onal dosage strengths: (1) For more severe cases ɔredominant anxiety*—ETRAFON-FORTE *(amitrip- HCl 25 mg. and perphenazine 4 mg.); (2) for cent or geriatric patients*—ETRAFON-A *(amitrip- HCl 10 mg. and perphenazine 4 mg.).* S-915

More certain broad-spectrum relief: ETRAFON is a broad-spectrum psychotherapeutic agent, capable of symptomatic relief not achieved with either drug alone in mixed emotional disorders. Pennington[6] states: "Since neurotic and psychotic anxiety and depression are simultaneously present in varying degrees, these two types of phrenotropic drugs in combination are more effective than either alone." Dorfman[7] and Coffee[4] report that patients unimproved on amitriptyline alone have responded to the combined therapy.

Low incidence of side effects: Mattey[8] ports that with ETRAFON "Side effects relatively few...." Another investigat states that side effects with amitriptyli perphenazine combination are less than w each component alone. In Penningto study of 428 patients, side reactions w less than half as frequent with ETRAFON with perphenazine alone, toxicity was l and the absence of extrapyramidal sy toms was regarded as "...particularly n worthy."[6]

NEW ETRAFO

brand of antidepressant-tranquil

amitriptyline hydrochloride 25 mg. and perphenazine 2

atomy of
w Back Pain #1



the sedentary life is often the seat of low back pain

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

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NEWS

Stanford Physician To Lecture At UF

Dr. Karl Pribram, of the Stanford University School of Medicine, Department of Psychiatry and Neuropsychology, will lecture at the University of Florida College of Medicine April 19th and 20th. Dr. Pribram was invited by Dr. Paul L. Adams of the UF Department of Psychiatry.

C. J. Stetler Elected President of PMA

C. Joseph Stetler, of Washington, D.C., was elected president of the Pharmaceutical Manufacturers Association on December 7, 1966. Stetler had been executive vice president and general counsel of the PMA since 1963. He has also been general counsel of the American Medical Association.

He succeeded Dr. Austin Smith, who was elected vice chairman and member of the executive committee of Parke Davis & Company on January 1, 1966. Dr. Smith was the first full-time president of the PMA, elected to that position in 1959 following his service as editor and managing publisher of the Journal of the American Medical Association.

UF Appoints New Chief of Medicine

Dr. Leighton E. Cluff, world renowned figure in infectious diseases and a major contributor to leading textbooks on internal medicine, was appointed professor and head of the Department of Medicine at the University of Florida College of Medicine on January 10, 1966.

Dr. Cluff was formerly a professor of medicine at Johns Hopkins University and head of its Division of Allergy and Infectious Diseases.

He succeeded Dr. Richard P. Schmidt, who was recently named associate dean of the University of Florida College of Medicine and chief of staff of the Shands Teaching Hospital and Clinics.

Florida Allergy Society Holds Interim Meeting

The Florida Allergy Society held an interim meeting at the British Colonial Hotel in Nassau on December 11th and 12th, 1965.

Dr. Austin T. Hyde Jr. discussed New Advances in the Uses of Allpryal Extracts.

Drs. Daniel N. Tucker, West Palm Beach; Ian K. Ajac, Hollywood; and Barry M. Seinfeld, Miami Shores were elected to active membership.

Canadian Physician To Lecture At UF

Dr. David Bates, associate dean of Graduate Studies and Research and professor of experimental medicine at McGill University, Montreal, Canada, will be visiting the University of Florida College of Medicine March 28th-31st for a series of rounds and conferences. Dr. Bates will then leave for the Florida Tuberculosis and Respiratory Disease Association meeting in Jacksonville April 1st and 2nd.

FMA Member Honored, Wins Surgery Award

Dr. D. Ralph Millard, clinical associate professor of surgery at the University of Miami School of Medicine, won first prize in the Senior Division of the 1965 International Scholastic Contest of the Foundation of the American Society of Plastic and Reconstructive Surgery.

The award was given on the basis of Dr. Millard's clinical work and research in the reconstruction of the total nose. In the last 15 years only five surgeons have won the Senior Division top prizes, and of these five only two have been Americans.


Whitney
Darrow, Jr.



It's a Mrs. Smith, Doctor Harris. Something about postnasal drip.

When you're called upon to provide quick relief for the sinusitis patient, Novahistine Singlet will usually do the job.

A single tablet provides prompt analgesic effect for relief of sinusitis pain. Then Novahistine Singlet also attacks the underlying cause of the headache—helping to open blocked respiratory passages and restore normal sinus drainage. The continuous decongestant effect produced by one Novahistine Singlet every 8 hours helps reduce the chance of acute sinusitis progressing to chronic stages.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that Novahistine may occasionally cause drowsiness. Each tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

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For relief of sinusitis pain and congestion.

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Association News

Eighth Annual Conference of County Medical Society Presidents and Secretaries Sponsored by the Florida Medical Association

The Eighth Annual Conference of County Medical Society Presidents and Secretaries, held in Orlando at the Robert Meyer Motor Inn on January 29 and 30, was attended by representatives of 32 of the state's 43 local societies. Total registration was 126.

President H. Phillip Hampton opened the two day meeting expressing the desire that the conference would prove as interesting and informative as had those in the past.

Following his opening remarks, Dr. Hampton introduced Dr. Ernest B. Howard, Assistant Executive Vice President of the American Medical Association.

Dr. Howard, speaking on the national medical scene, gave a synopsis of legislation leading up to the Medicare Act and set forth the current AMA position on that legislation. He said physicians should (1) make Title XIX work for persons under 65 who are insolvent; (2) support positive programming showing social concern, and (3) remember that ideological fervor alone does not win votes and support should be given all effective political action on the state and national scene.

Next on the program was a detailed discussion of Public Law 89-97 (Medicare). Panelists included Jack F. Monahan Jr., executive director of the Florida Hospital Association, speaking on Title XVIII A, which concerns hospitalization for those over 65 without the need to submit an application; Dr. Russell B. Carson, chairman of the National Association of Blue Shield Plans, who spoke on Title XVIII B, which concerns the voluntary supplemental insurance program upon the payment of $3 per month by the beneficiary, the federal government matching such funds; and Dr. H. Phillip Hampton, speaking on Title XIX, which he termed the only "good" part of the Medicare Bill, as it is an operational Eldercare program.

Dr. Wesley S. Nock, chairman of the FMA Committee on Child Health, reviewed the entire Head Start program and recommended that county medical societies should have their own programs of minimal medical standards and supervision in consultation with county health departments. He stated that his committee has been requested to establish standards for the medical portion of the Head Start program as guidelines for county medical societies at the earliest possible date.

Dr. Samuel M. Day, Immediate Past President, spoke on Public Law 89-239 (Heart Disease, Cancer and Stroke), and stated that the Florida Advisory Council on Heart Disease, Cancer and Stroke had been organized for statewide coordination, planning and development of programs which will be on a regional basis.

Following Dr. Day, those assembled heard Dr. Thad Moseley speak on scientific activities. Dr. Moseley covered the four committees of the FMA's Scientific Council—Research, Scientific Work, Postgraduate Education and The Journal and other publications. He stated The Journal serves in four important aspects: (1) as a forum for expression through scientific articles and editorials written by FMA members; (2) to make available specialized knowledge and recent developments in medicine; (3) to facilitate and improve public relations with the medical schools, and (4) to promulgate information concerning FMA committee and Council actions and recommendations and other matters of an administrative nature.

Dr. Moseley's remarks concluded Saturday's session.

Dr. George S. Palmer, President-Elect, presided over the Sunday morning session.

The first speaker was Dr. Irving E. Hall Jr., chairman of the Council on Medical Services. Dr. Hall's subject was the National Conference on Community Health Services.

David H. Reid, Ed.D., Blue Shield of Florida research analyst, spoke on the development of the prevailing fee concept. While introducing the speaker, Dr. Palmer emphasized that the prevailing fee questionnaires are merely for a study on which Blue Shield can base the premium for a contract of this nature; that a report will have to be made to the Board of Governors where modifications may be made and both the Board and the House of Delegates must give approval before this program could be instituted.

Sunday's meeting concluded with a discussion of county medical society programs and problems. Dr. William J. Dean, Pinellas County Medical Society president, represented the large county; Dr. I. Barnett Harrison, Leon-Wakulla-Jefferson County Medical Society president, the middle-sized county, and Dr. Martin G. Gould, St. Lucie-Okeechobee-Martin County Medical Society president, the small county.

Following an open discussion of county, state and national programs and problems, the conference was adjourned.

Board of Governors

In the meeting of January 15, 1966 held in Tampa, the Association's Board of Governors took the following actions:

FMA Budget 1966.—Approved the financial statement for 1965 and adopted the budget for 1966 of $275,000 plus $25,000 for reserve and land amortization, based upon an anticipated income of $300,000. In 1965, the Association's income was $311,578; expenses $270,891, for a gross gain of $40,687. Total assets of the Association as of Dec. 31, 1965, were $489,581.

Awards.—Accepted the offer of Mead Johnson to provide their Aesculapius Award of $200 for the best scientific exhibit at the Association's annual meeting. Second and third prizes also will be offered by the Association in the amounts of $50 and $25.

Considered nominations from the county medical societies for other Association awards to be presented at the annual meeting.

Prevailing Fee.—Reviewed a progress report regarding the prevailing fee questionnaires and reiterated that the questionnaires are merely for a study on which Blue Shield can base the premium for a contract of this nature; that a report will have to be made to the Board of Governors where modifications may be made and both the Board and the House of Delegates must give approval before this program could be instituted.

Health Insurance Council.—In answer to an inquiry, advised the Health Insurance Council that an effective working arrangement has been established between the Florida Medical Association and the Health Insurance Industry in Florida, that we shall continue and endeavor to improve this cooperative arrangement, and that we will cooperate with any qualified insurance carrier selected by the Secretary of Health, Education, and Welfare to implement the voluntary supplemental insurance program in Florida under Public Law 89-97.

Head Start.—Recommended that county medical societies should have their own programs of minimal medical standards and medical supervision in consultation with county health departments and that the FMA Committee on Child Health be requested to establish criteria for the medical portion of the Head Start program as guidelines for county medical societies at the earliest possible date.

Independent Laboratories.—Requested the Florida State Board of Health to form an Advisory Committee on Independent Laboratories.

AMA Board of Trustees.—Approved unanimously the recommendation of our AMA delegates to nominate Dr. Homer L. Pearson Jr., for re-election to the AMA Board of Trustees.

Heart Disease, Cancer, and Stroke.—Approved the Association's participation in the Florida Advisory Council on Heart Disease, Cancer and Stroke.

Title XIX P.L. 89-97.—Requested Governor Burns to designate Florida State Board of Health as the administering agency for Title XIX of Public Law 89-97.

One Board of Medical Examiners.—Considered resolution 65-10, One Board of Medical Examiners, which was referred to the Board for study by the 1965 House of Delegates. Heard a presentation from a delegation from the Broward County Medical Association and representatives from the Florida State Board of Medical Examiners, and deferred final recommendations until the next meeting of the Board of Governors.

Council and Committee Reports.—Reviewed numerous other reports of councils and committees and took appropriate actions where necessary. Among these were:

1. Approved the recommendations of the Scientific Work Committee for the scientific program at the FMA annual meeting, May 12-15, 1966.

2. Approved the recommendations of the Fee Schedule Committee dealing with Workmen's Compensation medical fee schedule; Dependents, military personnel; Veterans Administration; Vocational Rehabilitation.

3. Approved in principle the recommendations of the Committee on Nursing for a statewide survey on the shortage of nursing and paramedical personnel.

4. Reviewed the Committee on Pharmacy report which advised that unless the FMA was willing to recommend a change in AMA policy and declare physician ownership of pharmacies unethical, the pharmacists would support the Hart Bill. It was agreed that the Association make no change in its position on physician ownership of pharmacies and that the Council on Legislation be asked to investigate and oppose the Hart Bill.

5. Agreed with the report that the Association not endorse "vaginal irrigation" or "do it yourself" kits for detection of cancer of the cervix.

National Meetings in Florida

American Surgical Association, Boca Raton Hotel, Boca Raton, March 23-25.

American Clinical and Climatological Association, Ponte Vedra Inn, Ponte Vedra, Oct. 30-Nov. 2.

American Academy of Dermatology, American Hotel, Miami Beach, Dec. 3-8.

Southern Surgical Association, Boca Raton Hotel and Club, Boca Raton, Dec. 6-8.

Medical Licenses Granted

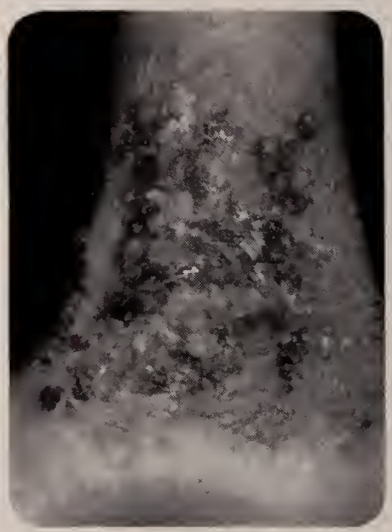
The Florida State Board of Medical Examiners report that of the 195 applicants who took the examination of the Board held November 21-23, at Jacksonville, 191 passed and have been issued licenses to practice medicine in Florida. The names, towns, medical school and year of graduation of the successful applicants follow:

Abers, Bernard David, Jersey City, N. J. (New York M.C. 1938)
Adcock, Kenneth Dan, Charlotte, N. C. (U. of Florida 1963)
Allen, Pliny Arunah, Williamstown, Mass. (Harvard M.S. 1934)
Allinson, Morris Jonathan, Benton, Ill. (U. of Arkansas 1945)
Altshuler, John Henry, Jacksonville, Fla. (McGill U. 1959)
Alvarez, Manuel Garcia, Lantana, Fla. (U. of Havana 1939)
Anderson, James Dick, Charlotte, N. C. (U. of Florida 1963)
Anspach, William Earl, Jr., Offutt AFB, Nebr. (Sanford U. 1962)
Arkin, Charles Frank, Miami Beach, Fla. (Northwestern U. 1964)
Armstrong, Robert Raymond, Philadelphia, Pa. (Temple U. 1956)
Bachman, Leonard, Bryn Mawr, Pa. (U. of Maryland 1949)
Barrett, Elizabeth Louise (f), Miami, Fla. (Cornell U. 1960)
Bear, Barbara Ellen (f), Miami, Fla. (Northwestern U. 1959)
Becker, Jasper Benoit, Jr., Pensacola, Fla. (Tulane U. 1960)
Bedell, David Thorpe, Jacksonville, Fla. (Columbia U. 1964)
Belmont, William Spain, N. Augusta, S. C. (Bowman Gray 1960)
Berman, Irwin Ralph, New York, N. Y. (U. of Virginia 1962)
Bew, David Fitzsimons, Jacksonville Beach, Fla. (Temple U. 1942)
Billingsley, Frank Sidney, Jacksonville, Fla. (U. of Arkansas 1958)
Black, Bruce Andrew, Warner Robins, Ga. (U. of Florida 1963)
Bork, Duane LeRoy, Jacksonville Beach, Fla. (U. of Iowa 1962)
Bosse, George, Cleveland, Ohio (Free U. Berlin 1951)
Bowers, Mirion Perry, Fort Dix, N. J. (Meharry M.C. 1963)
Brungard, Donald Alan, Miami, Fla. (U. of Miami 1964)
Bushoff, Stanley Hugo, Pittsburgh, Pa. (Hahnemann M.C. 1957)
Carter, James Earl, Merritt Island, Fla. (Marquette U. 1955)
Catherman, Robert Lewis, Miami, Fla. (Temple U. 1958)
Centurion, Manuel Jose, Miami, Fla. (U. of Havana 1955)
Cheshire, David Wilson, Milledgeville, Ga. (U. Mainz, Germany 1961)
Coane, Morton Raymond, Elkins Park, Pa. (Hahnemann M.C. 1943)
Cohen, Murray Joseph, Miami, Fla. (U. of Paris 1963)
Cooper, Samuel Long, Louisville, Ky. (U. of Louisville 1963)
Creveling, James Gordon, Jr., Richmond, Va. (Washington U. 1959)
Crews, Harry Denniston, Nashville, Tenn. (Johns Hopkins U. 1964)
Crino, Marjanne Helen (f), Miami, Fla. (Marquette U. 1959)
Davis, William Stewart, New Cumberland, Pa. (Jefferson M.C. 1952)
Delgado, Eduardo Emilio, Miami, Fla. (U. of Pittsburgh 1960)
Deren, Matthew Joseph, La Porte, Ind. (Indiana U. 1953)
Dillard, Guy Jackson, Jr., Gainesville, Fla. (M.C. of Georgia 1962)
Doyle, Joseph Preston, Camilla, Ga. (Washington U. 1944)
Dushoff, Ira Martin, Jacksonville, Fla. (U. of Pennsylvania 1956)
Epperson, John Wallace, Washington, D. C. (U. of Maryland 1943)
Erlich, Lawrence Benjamin, Gainesville, Fla. (U. Pennsylvania 1963)
Evans, William Benedict, Columbia, S. C. (M.C. Georgia 1959)
Fernandez, Jose Antonio, Middletown, N. Y. (U. of Havana 1943)
Ferris, Gilbert Nelson, Key West, Fla. (Seton Hall C.M. 1961)
Fix, Ivor, Miami Beach, Fla. (U. of Witwatersrand 1952)
Flynn, Leo Michael III, Gainesville, Fla. (U. of Florida 1964)
Frydman, Joseph E., Jacksonville, Fla. (U. Illinois 1961)
Galainena, Mariano Luis, Cleveland, Ohio (U. of Havana 1948)
Garcia, Juana Morales (f) Chicago, Ill. (U. of Havana 1946)
Garcia, Julian Fernando, Ft. Lauderdale, Fla. (U. of Havana 1953)
Gayler, Bob Winn, Baltimore, Md. (U. of Florida 1963)
Gear, Arthur Sewell, Jr., Richmond, Va. (M.C. Virginia 1959)
Gershen, Herbert Joel, Forest Hills, N. Y. (Chicago M.S. 1963)
Giammona, Samuel Thomas John, Coral Gables, Fla. (Yale U. 1954)

Gilbert, Carl Norman, Atlanta, Ga. (Emory U. 1964)
Gillen, John Bernard, Jr., Jacksonville, Fla. (U. Cincinnati 1962)
Glasser, Harvey Allen, Ft. McClellan, Ala. (New York M.C. 1964)
Glatch, Louis F., Jr., Miami, Fla. (George Washington U. 1960)
Goldman, Harry Nathan, Miami, Fla. (U. of Berne 1935)
Goldwyn, Robert Henry, Eglin AFB, Fla. (U. of Miami 1964)
Gomez, Jose Rogelio, Ft. Lauderdale, Fla. (U. of Havana 1960)
Gomez, Nichols Humberto, Rock Island, Ill. (U. of Havana 1953)
Gordon, John Russell, Hollywood, Fla. (Manitoba M.S. 1940)
Griffith, Donald Paul, Jacksonville, Fla. (Baylor U. 1963)
Guin, Thomas Duvall, Durham, N. C. (Duke U. 1958)
Gustafson, Gerald Edward, Dallas, Texas (U. Missouri 1961)
Guynn, Cyrus Harding, Gainesville, Fla. (Duke U. 1961)
Hanna, Stanley George, Williamsburg, Va. (U. of Miami 1964)
Hardman, Alvin Abrams, Gainesville, Fla. (U. of Florida 1964)
Hart, Martin, Detroit, Mich. (Wayne State U. 1964)
Havre, Dale Charles, Winter Park, Fla. (Western Reserve U. 1961)
Hogan, William Francis, Jacksonville, Fla. (Geo. Washington U. 1961)
Holder, David Lee, Winter Park, Fla. (U. of N. C. 1959)
Holton, Charlene Poland (f), Memphis, Tenn. (U. of Miami 1963)
Howard, Moses Wilkerson, Knoxville, Tenn. (U. of Louisville 1933)
Hurwitz, Alfred, Miami Shores, Fla. (Johns Hopkins U. 1933)
Iannuzzi, Elio, Fitchburg, Mass. (U. of Naples 1951)
Isbell, Euclid Arnold, Jr., Philadelphia, Pa. (Tulane M. S. 1963)
Itkin, Ernest Louis, Brooklyn, N. Y. (Cordoba U. 1959)
Johnson, Herbert Cecil, Mobile, Ala. (M. C. Alabama 1964)
Jones, James Kenda, Birmingham, Ala. (M. C. Alabama 1953)
Kerr, William Dodge, Jr., Miami, Fla. (Johns Hopkins U. 1960)
Kinzie, Joseph Lee, Jr., Chapel Hill, N. C. (U. of Virginia 1964)
Kirk, Thomas Esben, Gainesville, Fla. (U. of Missouri 1962)
Kraines, Richard Lee, Chicago, Ill. (U. of Chicago 1963)
Kronis, Alex Dimitrios, Cleveland Hts., Ohio (Aristotelian U. 1952)
Kurstin, Morton Joseph, Miami, Fla. (U. of Miami 1964)
LaFia, David Joseph, Philadelphia, Pa. (Jefferson M. C. 1947)
Lastra, Jose Sequndo, Miami, Fla. (U. of Havana 1925)
Lee, Kathern Marie (f), Jacksonville, Fla. (U. of Tennessee 1964)
Lever, Peter Gordon, Hollywood, Fla. (London Hosp. M. S. 1949)
Lloyd, Harry Davidson, Charlotte, N. C. (U. of Florida 1964)
London, William, Roslyn, L.I., N. Y. (Long Island C. M. 1932)
Lopez, Rolando, Islamorada, Fla. (U. of Havana 1957)
Lopez-Gomez, Alfredo Angel, Miami, Fla. (U. of Havana 1954)
Marder, Leon, Gainesville, Fla. (U. of Oklahoma 1949)
Martin, David William, Jr., Durham, N. C. (Duke U. 1964)
Mas, Ildefonso Rafael, Coral Gables, Fla. (U. of Havana 1948)
Mattes, Charles Louis, Jr., Winter Haven, Fla. (U. of Louisville 1946)
Mattingly, Maurice Edwin, Jr., Tampa, Fla. (U. of Tennessee 1964)
Mattison, Joel William Lewis, Gainesville, Fla. (Duke U. 1961)
McCarthy, Owen Michael, Patrick AFB, Fla. (Georgetown U. 1962)
McCullagh, William Henry, Jr., Atlanta, Ga. (Emory U. 1963)
McDonald, Andrew Wellington, Lake City, Fla. (Western Reserve U. 1941)
McElroy, Andrew Harper, Jr., Durham, N. C. (M. C. Alabama 1958)
McNeil, Mary Carolynn (f), Long Beach, Calif. (Loma Linda U. 1953)
Mehring, Samuel Stuart, Youngstown, Ohio (Temple U. 1962)
Menedez, Aristides, Coral Gables, Fla. (U. of Havana 1941
Mijares, Jose Alfredo, Tampa, Fla. (U. of Havana 1943)
Million, Rodney Reiff, Gainesville, Fla. (Indiana U. 1954)
Mindel, Joel Sidney, New York, N. Y. (U. of Maryland 1964)
Mingledorff, Walter Etheridge, Jacksonville, Fla. (Emory U. 1958)
Moliken, Murray Harris, Riverside, N. J. (Jefferson M. C. 1963)
Morada, Angustia Ocampo (f), Lake City, Fla. (U. Santo Tomas 1957)
Moreau, Frank William, Miami, Fla. (U. of Miami 1964)
Moskowitz, Jerome, N. Miami Beach, Fla. (Chicago M. S. 1962)
Muench, Karl Hugo, Miami, Fla. (Washington U. 1960)
Munach, Sheldon Daniel, Miami, Fla. (Calif. Coll. Med. 1962)
Newman, Paul Kenneth, Jacksonville, Fla. (Temple U. 1962)
Olson, Clyde Lewis, Key West, Fla. (Johns Hopkins U. 1961)
Ouzts, Len Moore, Jacksonville, Fla. (M. C. of Ala. 1963)
Owen, James Caney, Jr., Tampa, Fla. (U. of Tennessee 1964)
Pena, Jorge Raul, Miami, Fla. (U. of Havana 1946)
Peterson, George Edward, Miami, Fla. (Seton Hall C. M. 1962)
Pfaff, William Wallace, Gainesville, Fla. (U. Buffalo 1956)
Poliak, Claude Roger, Tampa, Fla. (Seton Hall C. M. 1960)
Portela, Raul, Miami, Fla. (U. of Havana 1951)
Potter, John Kenneth, Cleveland, Ohio (Hahnemann M. S. 1934)
Quick, Donald Thomas, Gainesville, Fla. (Western Reserve 1959)
Ramos, Mario Sergio, Lake City, Fla. (U. of Havana 1946)
Richman, William, Cherry Hill, N. J. (Temple U. 1952)
Rigsby, Robert Edgar, Tampa, Fla. (M. C. of Georgia 1958)
Riopel, Donald Aimé, Richards-Gebaur AFB, Mo. (U. of Florida 1963)
Rogers, Doyle Nolan, Pensacola, Fla. (U. Texas Southwestern 1963)
Ruiz, Agustin, Tampa, Fla. (U. of Mexico 1950)
Rupp, Joseph Charles, Ft. Lauderdale, Fla. (Western Reserve 1961)
Sabates, Felix Nabor, Columbia, Mo. (U. of Havana 1955)
Sanchez, Jose Antonio, W. Hollywood, Fla. (U. of Havana 1948)
Sanguinetti, Alberto Ambrosi, Chattahoochee, Fla. (U. Buenos Aires 1929)
Sandall, Edward Warren, Jacksonville, Fla. (U. of Nebraska 1960)
Sanders, Sandy Kent, Gainesville, Fla. (U. of Florida 1964)
Sardinas, Adolfo Andres, Chelsea, Mass. (U. of Havana 1954)

(Continued on page 232)

eczema: scourge of childhood



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Dosage: One or two tablets, one-half hour before bedtime.

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1. Weese, H.: Personal Communication, Sept. 25, 1964. 2. Glynn, R.: Obst. & Gynec. 20:369, 1962.

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(Continued from page 229)

Scarvey, Frank III, Gainesville, Fla. (U. of Tennessee 1961)
Schaye, Gordon Fels, Norfolk, Va. (Washington U. 1963)
Segaul, Arthur Irving, Jacksonville, Fla. (St. Univ. (Syracuse) 1956)
Selwin, Norman Hyman, Miami, Fla. (U. of Lausanne 1960)
Shaner, Alice Lucille (f), Miami, Fla. (U. of Miami 1964)
Sheldon, Jerome Jay, Miami, Fla. (U. of Miami 1964)
Sheppard, Jimmy Clyde, Gainesville, Fla. (M. C. of Ala. 1960)
Sherk, Cecil Sidney, Tampa, Fla. (U. of Cincinnati 1964)
Sherwood, Janice Kane (f) Miami Beach (Chicago M. S. 1960)
Shortz, Gerald Kent, Orlando, Fla. (Northwestern U. 1962)
Simes, David Leo, Maxwell AFB, Ala. (U. of Pa. 1954)
Sirhal, Alfred Morris, Brooklyn, Mich. (Loyola U. 1939)
Slavin, Douglas, Miami, Fla. (U. of Virginia 1964)
Sloan, Beatrice Schiller (f), Deerfield Beach, Fla. (Woman's M. C. 1946)
Sluchak, Max, Eglin AFB, Fla. (U. of Puerto Rico 1964)
Smith, Frederick Oliver, Jacksonville, Fla. (U. of Florida 1964)
Smith, Richard Bruce, Cleveland, Ohio (Trinity College 1952)
Spaan, Donald Wade, Inglewood, Calif. (U. of Iowa 1955)
Spivey, Don Morrison, Eglin AFB, Fla. (U. Arkansas 1963)
Stone, Mario Martin, Augusta, Ga. (U. of Havana 1942)
Taylor, Robert Shanks, St. Petersburg, Fla. (U. of Chicago 1964)
Telle, James Thomas, Langley AFB, Va. (Indiana U. 1963)
Thorne, Frank Leadley, Durham, N. C. (U. of Pa. 1957)
Thornton, Eleanor (f), W. Palm Beach, Fla. (Johannes Gutenberg U. Mainz 1964)
Toch, Herbert, Jacksonville, Fla. (U. of Pa. 1960)
Vacha, Victoria Barbara (f), Orlando, Fla. (Loyola U. 1947)
Valdes, Osvaldo Diaz, Miami, Fla. (U. of Havana 1960)
Vernace, Frances Mary (f), Jamaica, N. Y. (State U. N. Y. (downstate) 1964)
Via, Bobby Mack, Eglin AFB, Fla. (U. of Texas Southwestern 1963)
Viamonte, Manuel, Miami, Fla. (U. of Havana 1955)
Viamonte, Maria (f), Miami, Fla. (U. of Havana 1955)
Virgin, Charles Edward, Evanston, Ill. (Duke U. 1964)
Visintine, Aarolyn Marie (f), Miami, Fla. (Ohio State U. 1963)
Waldman, Irving, Dayton, Ohio (U. of Buffalo 1958)
Watson, John D., Jr., Metairie, La. (U. of Arkansas 1955)
Wegmann, Norbert John, Montgomery, Ala. (Marquette U. 1958)
Wester, Juan Sven Aage, Hollywood, Fla. (Buenos Aires U. 1959)
Wheelock, Mark Carroll, Miami, Fla. (State U. of Iowa 1930)
Whitmire, Leslie Earl, Ft. Lauderdale, Fla. (Ohio State U. 1952)
Williams, Frank Mathews, Baltimore, Md. (Harvard U. 1964)
Willis, Irvin Howard, Miami, Fla. (U. of Cincinnati 1964)
Wilson, Ronald Maurice, Orlando, Fla. (M. C. of Georgia 1961)
Wooden, William Rogers, Jacksonville, Fla. (U. of Colorado 1962)
Worthington, David Charles, Brandon, Fla. (Temple U. 1961)
Xydakis, Stephanos Antonios, Chicago, Ill. (U. of Athens, Greece 1956)
Yozgatlioglu, Cuneyt Abdulla, Gainesville, Fla. (U. Istanbul, Turkey 1951)
Zeppa, Robert, Miami, Fla. (Yale U. 1952)

Medical Manuscript Editing Service

For more than 10 years, the American Medical Writers' Association has provided a Medical Manuscript Editing Service, available to members and nonmembers of the association. The charge to members is $5 for the first 1,000 words plus $5 for each additional thousand or fraction thereof. The charge to nonmembers is $7.50 for the first 1,000 words plus $7.50 for each additional thousand or fraction.

Only manuscripts intended for medical journals or kindred publications, from which the authors receive no fees and which do not exceed 5,000 words in length, will be accepted for review and editing. Corrections, made on the manuscript itself, cover punctuation; capitalization; spelling; misused words, including medical terms; and arrangement of bibliography. In addition, line-by-line criticism of the manuscript covers such points as title, organization, tables and illustrations, subheads and summary, as well as grammar, syntax and usage. The principal aim is to help authors say what they want to say and to say it with precision, economy, and grace.

Manuscripts must be sent by first class mail, typewritten, in English, double or triple space, with wide margins at top, bottom, and both sides, written on one side only, and accompanied by return first class postage. It is preferred that manuscripts be mailed flat; the number of words in the manuscript must be stated in the upper right hand corner of the first page; and the fee for the service including return postage, should be enclosed. The author should be sure to retain a copy of his paper. All manuscripts should be sent to the American Medical Writers' Association, Medical Manuscript Editing Service, Ravenswood Hospital, Chicago, Illinois 60640.

Leukemias and the Anorectal Area

The development of anorectal complications in a patient with leukemia signals an early demise of the person so afflicted. So reports Dr. William C. Bernstein, Clinical Professor of Surgery and Director of the Division of Proctology at the University of Minnesota Medical School.

(1) A 70 year old white man with myelogenous leukemia died 24 days after a perirectal abscess developed.

(2) A 13 year old white girl died two and one-half weeks after a bullous edema of the anal area developed.

(3) A 60 year old white man died three months after leukemic infiltrate developed in the perianal and perineal regions.

(4) A 59 year old white woman died one month after necrotic lesions in the anal canal developed.

(5) A five year old white girl died two weeks after the onset of an anal lesion.

(6) A 12 year old white girl died one month after anal ulceration developed.

(7) An 18 year old white woman had oral and anal lesions which developed rapidly after the detection of leukemia. Death ensued in six weeks after the onset of the illness.

(8) A 29 year old white man with a three month history of leukemia had induration in the rectal ampulla. He died two weeks after the onset of the rectal problem.

All eight of these patients were observed by Dr. Bernstein and his associates within a two year period. His paper entitled "Gastrointestinal Complications of the Leukemias" will be published soon in Diseases of the Colon and Rectum, the official journal of the American Proctologic Society.

Dr. Bernstein pointed out that virtually all of the organ systems in the body may be involved in a leukemic patient. Involvement of the lower gastrointestinal tract, however, and particularly the anorectal area, is an infrequent occurrence. The anorectal complications of the leukemias are characterized by thrombosis, necrosis, ulceration, sloughing and sometimes abscess formation. These changes may or may not be accompanied by leukemic infiltration of the anorectal area. The occurrence of these lesions in the patient with acute leukemia is a grave prognostic sign. Most patients will expire two to three weeks after the appearance of the anal lesion.

The treatment of anorectal lesions should be conservative. Intervention is indicated only for the release of obvious collections of pus.

Anorectal complications of leukemia have received little notice in the literature. Only a few published reports show the relationship between hematological disorders and anorectal disease. The author is to be congratulated for bringing these important facts to the attention of the medical profession.

John Cheleden, M.D., President
Florida Proctologic Society
Daytona Beach

Others Are Saying



Drug Product Equivalency

Addressing the Hillsborough County Medical Association recently, A. E. Slesser, Ph.D., of Smith, Kline & French Laboratories, discussed "The Myth of Drug Product 'Equivalency.'" He presented the concept of drug quality and the drug quality control function in assuring therapeutically reliable drug products, and explained why so-called equivalency of cheaper products that purport to be the same is a myth.

"The term *drugs* has been the source of much confusion," Dr. Slesser said. "People say *drug* when they mean *drug product*. . . . *A drug product* consists of the chemical compound (the *drug* which produces the therapeutic effect) in combination with one or many other substances that must be used to make the tablet, capsule, injection, etc. . . . The nature of the other substances which must be admixed with the drug (and there may be from one to twenty or more in a tablet, capsule, etc.); the manner in which the admixture is done; the number and type of quality controls applied at each step of manufacture—all of these can affect the therapeutic efficacy of the dosage form. . . . "The most important quality of a drug product is clinical effectiveness—the reliability that it will perform as it is expected to perform each time it is used . . . without clinical reliability, prescribing, dispensing or administering the drug product may become a medical variation of 'Russian Roulette.'" The one way to assure the therapeutic efficacy of a drug product is by properly designed and controlled clinical tests, Dr. Slesser observed; yet, there is a widely prevalent tendency to confuse drug *content* of a drug product with drug *potency* or clinical effectiveness. He discussed five systematic, effective quality control procedures which are the responsibility of the manufacturer of the drug products: components; formula; manufacturing (or compounding) procedure; analytical tests, inspections and checks; and in-process controls to verify that all four of the preceding factors have actually been applied. In support of his thesis that generic equivalency is frequently a fable without basis in fact, he continued:

"It is true that the prices of certain manufacturer's generic-name 'equivalent' drug products are sometimes much lower than those of trademark products made by reputable and qualified manufacturers, because producers of the former are not innovators. They do not discover and develop new drugs through research. And most of them also economize by taking production, quality control and marketing shortcuts.

"But, as many studies show, all drug products having the same generic name are not identical. Some generic-name drug products are of excellent quality; some are not. Unless the product (whether marketed under generic or brand name) is made by a reputable and qualified manufacturer, there is absolutely no way to tell which is good and which poor—before it is used—without the use of analytical and biological laboratory facilities more elaborate than most physicians, pharmacists and hospitals are likely to possess.

The discomforts of

DIARRHEA
MUCOUS COLITIS
DIVERTICULITIS
SPASTIC URETERITIS
BLADDER SPASM

. . . are relieved by direct musculotropic action with

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BRAND THIPHENAMIL HCl

Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly. The usual initial dose is 4 tablets. Maintenance dosage is usually one or two tablets 4 times a day.

Trocinate *BRAND* THIPHENAMIL HCl

BETA-DIETHYLAMINOETHYL DIPHENYLTHIOACETATE HYDROCHLORIDE

. . . directly relaxes smooth muscle spasm
. . . combats hypermotility
. . . non-mydriatic – may be used in glaucoma

Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

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Manufacturers of ethical pharmaceuticals since 1856



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

WALLACE LABORATORIES
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Night Leg Cramps...
Frequent Bedfellow in Diabetes, Arthritis, and Peripheral Vascular Disorders*



*"Nocturnal cramps occurring in the calf muscles and small muscles of the feet have been encountered in a significant number of diabetic patients."[1]

"... nocturnal cramps may be the presenting symptoms of patients with arteriosclerosis obliterans, deep thrombophlebitis, varicose veins, osteoarthritis..."[2]

now...specific therapy for night leg cramps

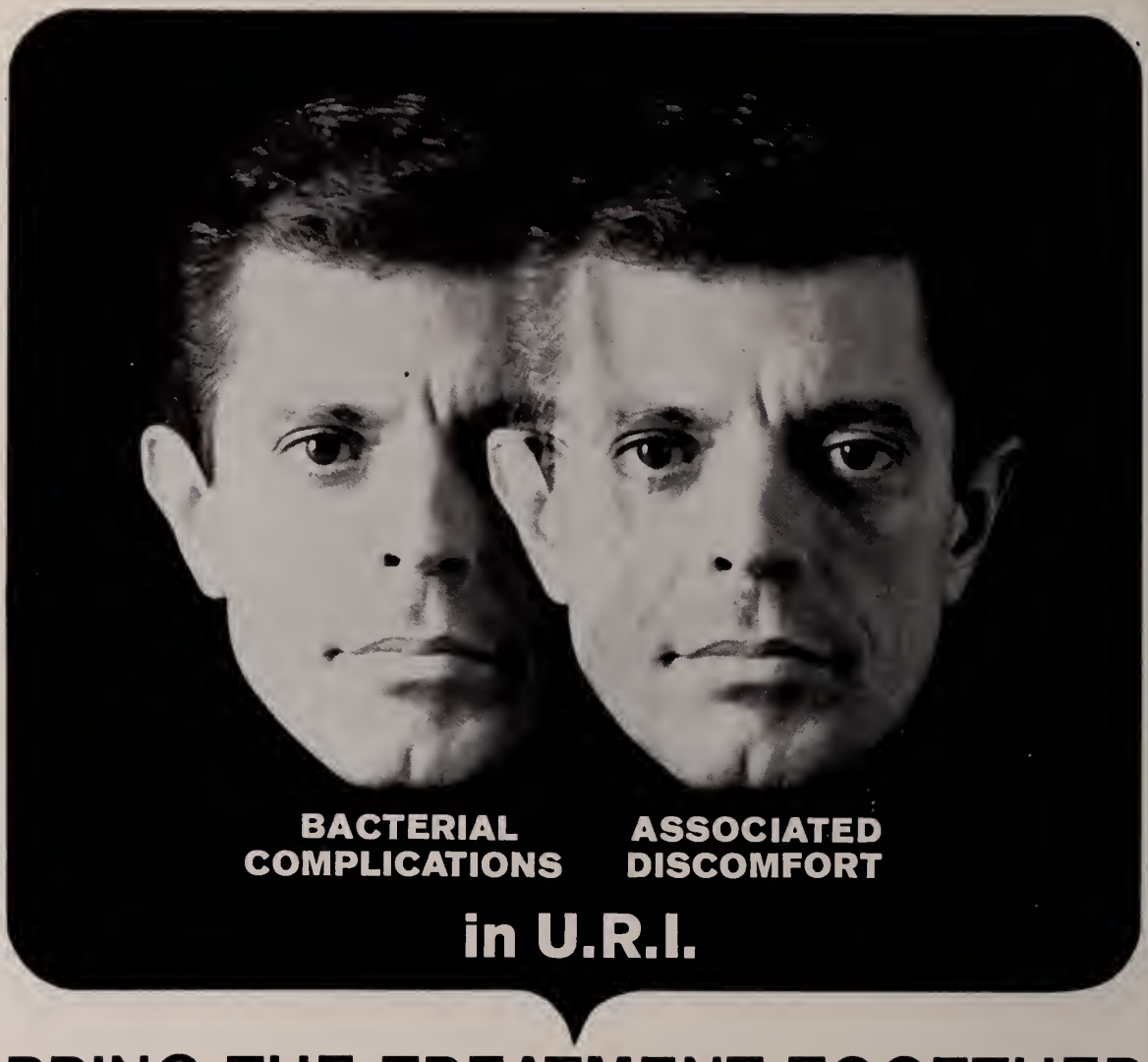
QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

QUINAMM Prescribing Information: Composition: quinine sulfate 250 mg. and aminaphylline 200 mg. per tablet. **Precautions:** aminaphylline may produce intestinal cramps in some instances, and quinine may produce symptams af cinchanism such as tinnitus, dizziness, and gastraintestinal disturbance. Discantinue if ringing in the ears, deafness, skin rash ar visual disturbances accur. Since Quinamm cantains quinine sulfate, cautian shauld be observed regarding administratian during pregnancy. Dasage: 1 tablet three ar faur times daily. Far nacturnal leg cramps, 1 tablet an retiring.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et al.: Angialagy, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

WALKER Laboratories Division of Richardson-Merrell Inc. Mt. Vernon, New York 10551



BRING THE TREATMENT TOGETHER IN A SINGLE PRESCRIPTION

ACHROCIDIN®

Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:			
ACHROMYCIN® Tetracycline HCl	125 mg	Caffeine	30 mg
Acetophenetidin (Phenacetin)	120 mg	Salicylamide	150 mg
		Chlorothen Citrate	25 mg

Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects include drowsiness, slight gastric distress, anorexia, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation), photodynamic reaction to sunlight and increased intracranial pressure (in young infants). Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals. Patient should avoid direct exposure to artificial or natural sunlight; and should not drive a car or operate machinery while on drug. Reduce dosage in impaired renal function. Stop drug immediately at the first sign of adverse reaction.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

Lederle

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Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.



mood elevation

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Anorecti
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DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 table sections, combined back to back to form a singl tablet. One section contains Desoxyn to curb th appetite and lift the mood; the other contain Nembutal® (pentobarbital) to calm the patient an counteract any excessive stimulation.

Both drugs are released in an effective dosag ratio throughout the day.



controlled release

Abbott
Anorectic
Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

Abbott
Anorectic
Program

DESOXYN Gradumet
Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



Front Side

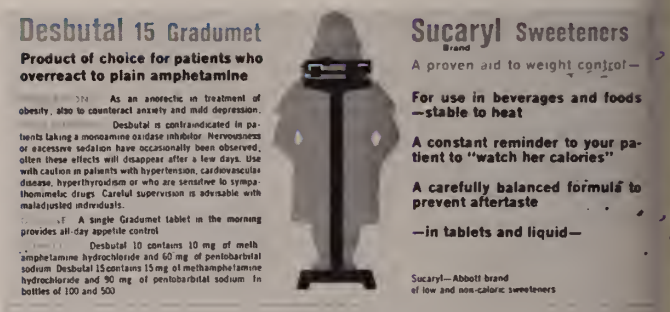
DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium

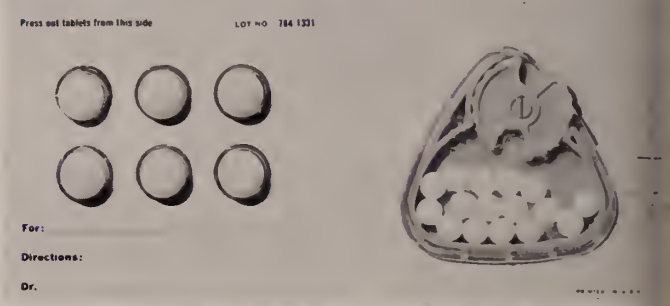


Front Side

samples available







Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.

economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

ABBOTT

Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
Sucaryl—Abbott brand of low and non-caloric sweeteners.

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METHISCHOL

original lipotropic formula

In the management of disorders associated with deficiencies of lipotropic substances and B complex vitamins, METHISCHOL is outstanding as a supplementary source of these factors.

Methischol Capsules are available in bottles of 100, 250, 500, 1000;
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Butazolidin® alka

phenylbutazone	100 mg.
dried aluminum hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
homatropine methylbromide	1.25 mg.

Usually works within 3 to 4 days in osteoarthritis

The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is *at least 1 month.*

That's why it's logical to start therapy with Butazolidin alka—you'll know quickly whether or not it works. And usually, it will.

A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile, or when other potent drugs are given concurrently. Large doses are contraindicated in patients with glaucoma.

Precautions
Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

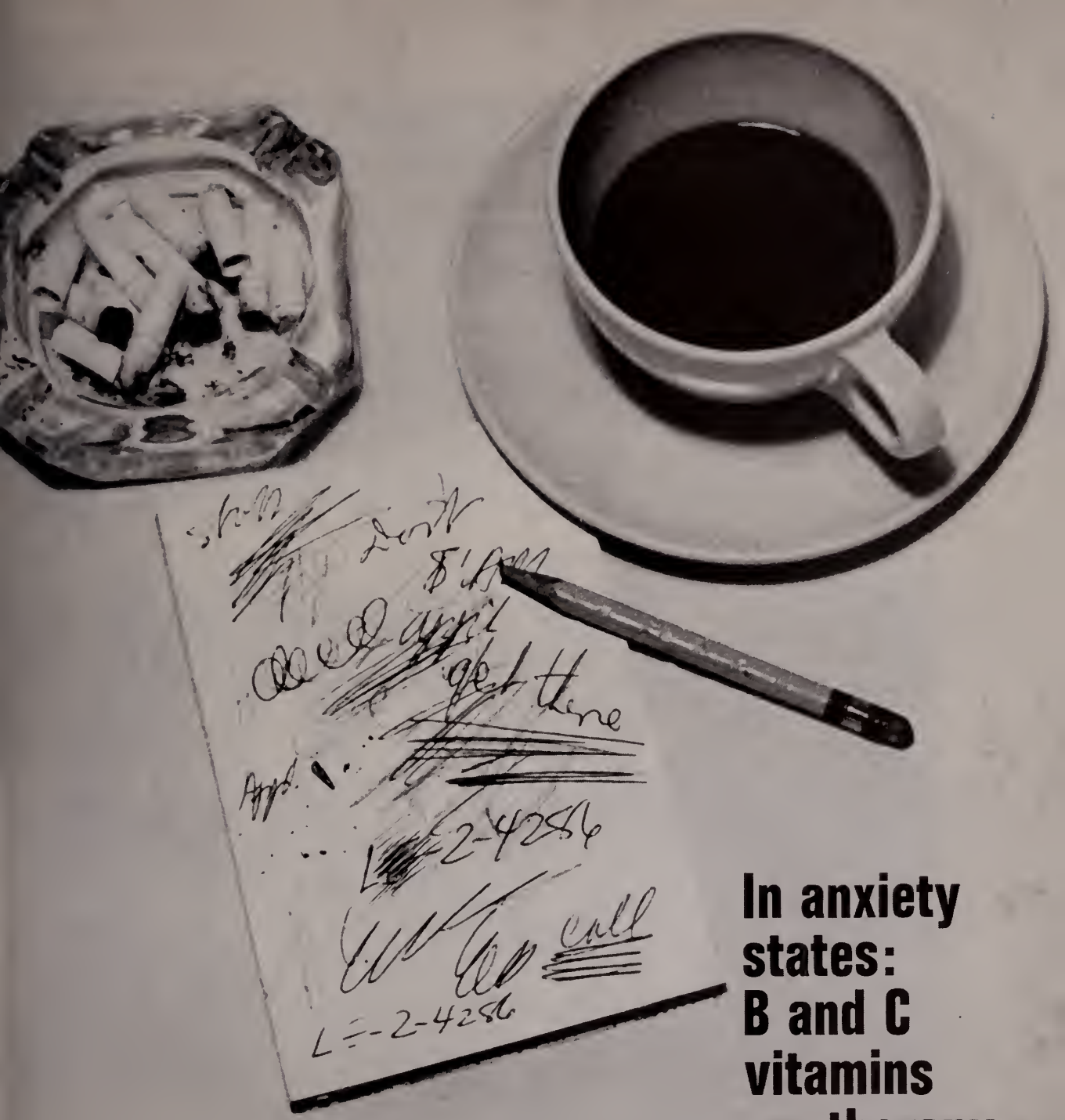
Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria, hematuria. With long-term use, reversi thyroid hyperplasia may occur infrequ

Dosage
The initial daily dosage in adults is 300 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. Wh improvement occurs, dosage should b creased to the minimum effective level should not exceed 400 mg. daily, and i often achieved with only 100-200 mg. d

Also available: Butazolidin®,
brand of phenylbutazone
Tablets of 100 mg.

Geigy Pharmaceuticals
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Ardsley, New York BU-

Geigy



In anxiety states: B and C vitamins are therapy

tress formula vitamins are an important supportive measure in main-aining the nutritional status of the emotionally disturbed patient. With TRESSCAPS, B and C vitamins are present in therapeutic amounts to meet ncreased metabolic demands. Patients with anxiety, and many others under-oing physiologic stress, may benefit from vitamin therapy with STRESSCAPS.

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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FOR PROFESSIONAL RECOMMENDATION ONLY

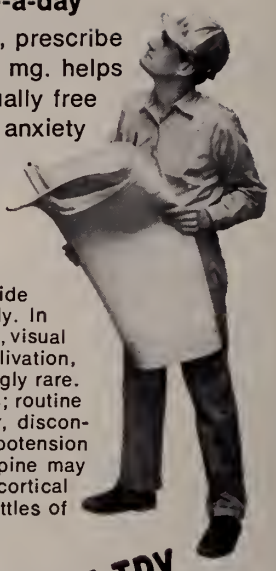
Stress Formula Vitamins Lederle

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

0241-4

Blueprint for dealing with tension due to stress — Prolixin — once-a-day

For the patient who must be on the job mentally as well as physically, prescribe Prolixin. The prolonged tranquilizing action of as little as one or two mg. helps him cope with tension all day long. Markedly low in toxicity and virtually free from usual sedative effects, Prolixin is effective in controlling both anxiety associated with somatic disorders and anxiety due to environmental or emotional stress. Patient acceptance is good — because Prolixin is low in cost, low in dosage and low in sedative activity. Prescribe Prolixin.



Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

PROLIXIN®

THE SQUIBB TRANQUILIZER

SQUIBB FLUPHENAZINE HYDROCHLORIDE

SQUIBB Squibb Quality — the Priceless Ingredient

when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

Geriliquid®



IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.

Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

Supplied: Bottles of 8 oz. and 16 oz.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

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Consult an architect!

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Call the phone company!

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YOUR GUILD OPTICIAN!

Specialized services demand specialized knowledge. That's why an architect is consulted when you want the construction you contemplate to be properly planned. It's why you call the phone company when you want your telephone service extended or revised . . . and it's why you should call on your Guild Optician for optical services of any kind.

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When you write a prescription, above all you expect to have that Rx properly filled so the patient obtains the full benefit of your professional services. You also expect to have your patient receive after-service for the life of his glasses. That's why it's wise to call on an expert — your Guild Optician. *Guild of Prescription Opticians of Florida.*

USING GUILD SKILLS AND EXPERIENCE TO SERVE YOUR PATIENTS



more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

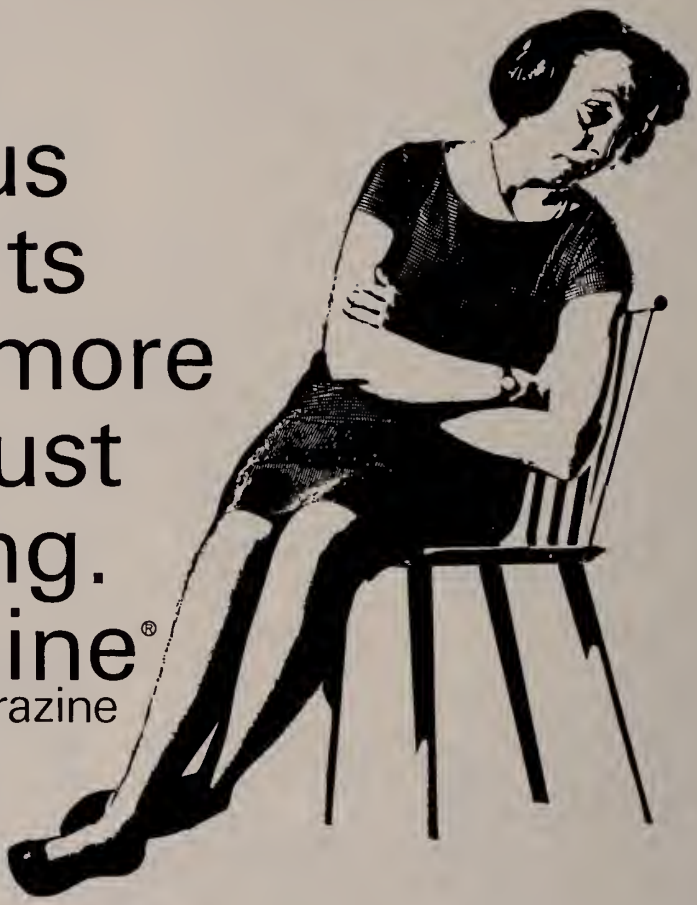
Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

Many anxious patients need more than just calming. Stelazine®

brand of trifluoperazine

offers true tranquilization.



Sedative or muscle relaxant-type tranquilizers are often all that's needed for patients with temporary situational anxiety. But in the many patients whose anxiety presents a continuing problem these agents are limited by their generalized dulling effects.

'Stelazine' can attack anxiety directly without producing annoying dulling effects. On 'Stelazine', patients can react more normally to day-to-day stress yet remain alert, able to carry on their normal activities.

Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems. Before prescribing, see SK&F product Prescribing Information.

SK&F Smith Kline & French Laboratories, Philadelphia

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

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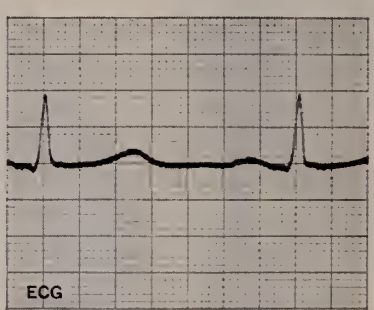
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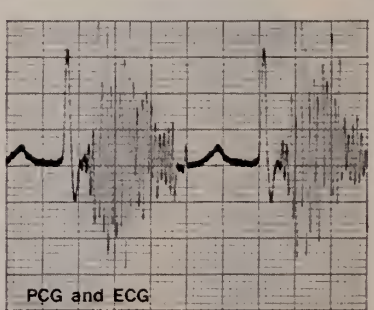
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DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

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IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

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PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease, advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or disfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

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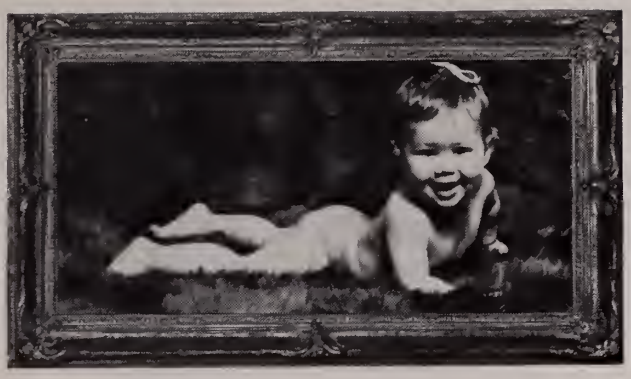
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"The main function of the carotid sinus is regulation of the blood pressure...."[1]

The veratrum component of Salutensin acts here (and in the myocardium), initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."[2]



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Salutensin enhances the body's own mechanisms for lowering blood pressure. The veratrum component of Salutensin acts on the carotid sinus and myocardial receptors, initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."[2] To achieve this reflex modification of hypertension, Salutensin utilizes protoveratrine A. In addition, to facilitate and maintain blood pressure reduction, Salutensin incorporates reserpine and a highly effective thiazide. In general, side effects have been reported infrequently but may include those listed in the therapeutic summary.

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Available: Prescription-size bottles of 60 tablets.

References: 1. Editorial: JAMA *191*:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: Hypertension, Philadelphia, W.B. Saunders Company, 1959, p. 395.

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For complete information consult Official Package Circular.
Indications: Essential hypertension.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs.
Contraindications: Salutensin is contraindicated in severe depression.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).
Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet *b.i.d.*

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METATENSIN®

Each scored tablet contains:
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2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

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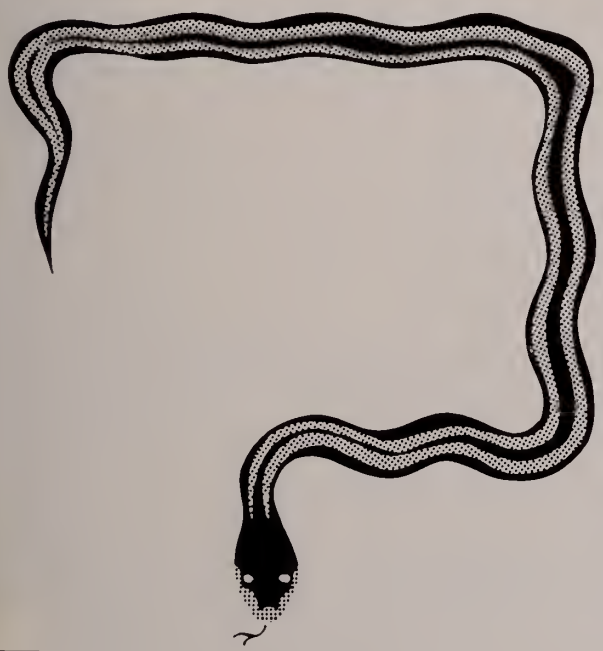
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1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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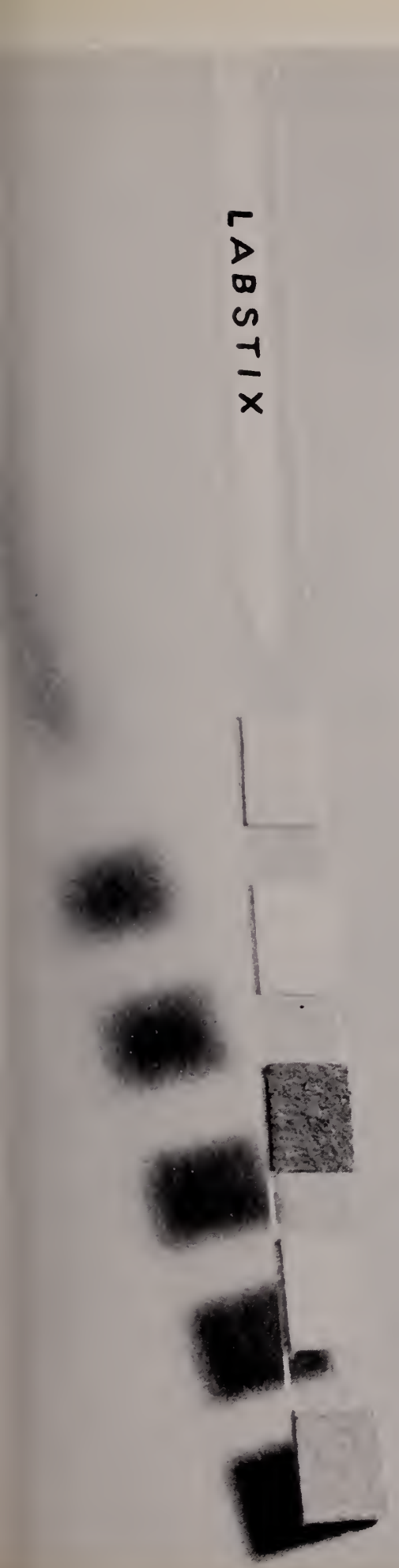
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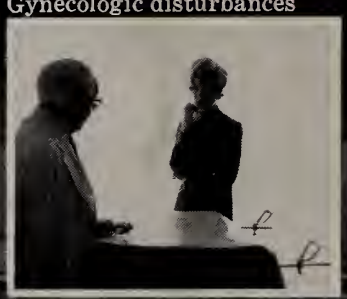
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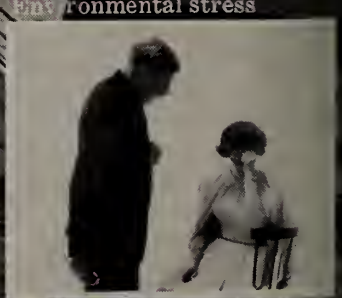
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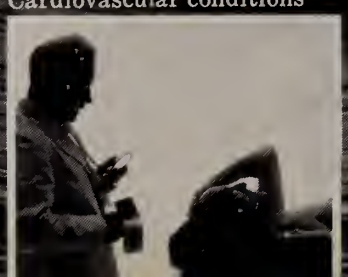
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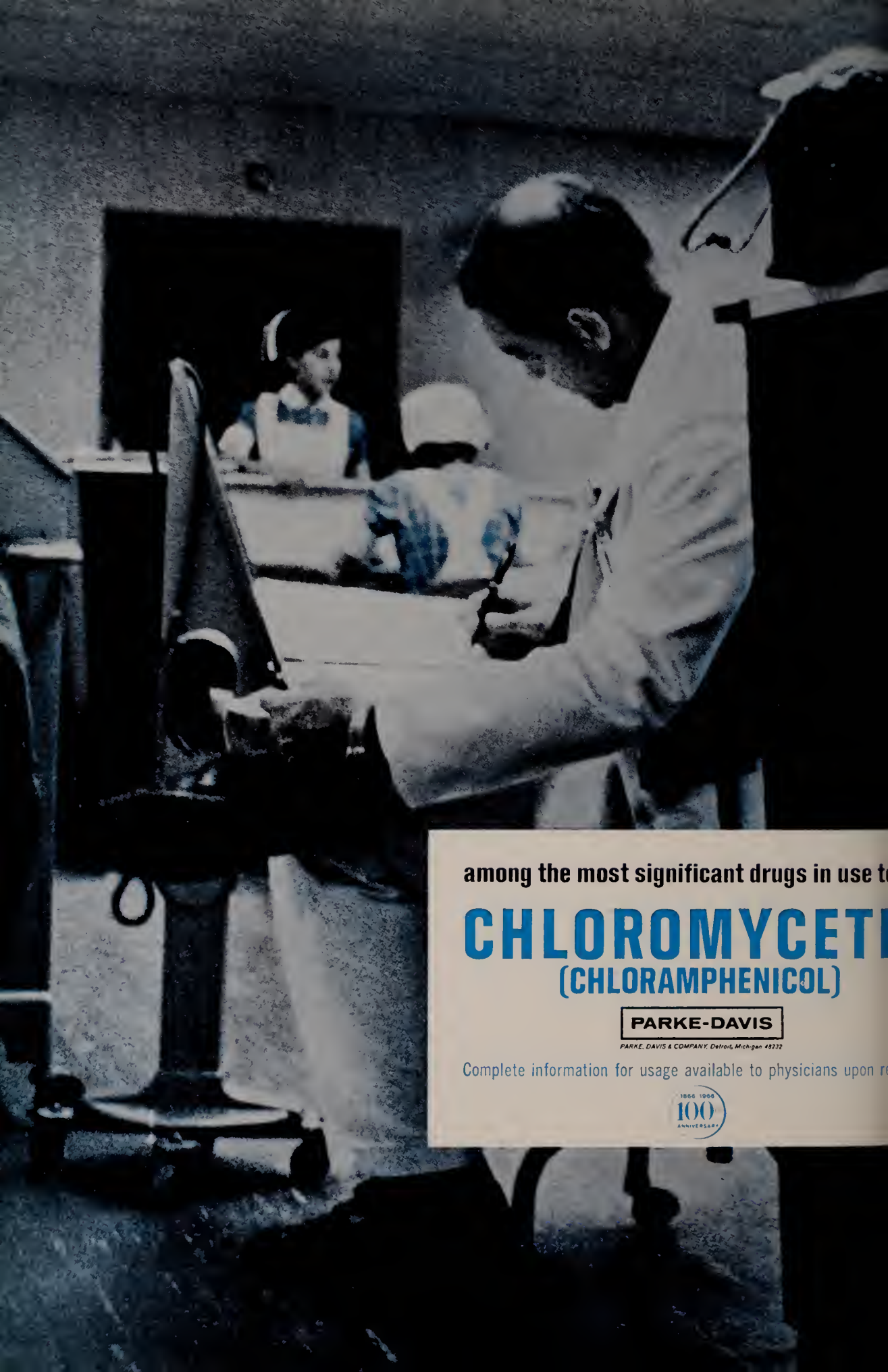
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Number 4

The JOURNAL of the Florida Medical Association

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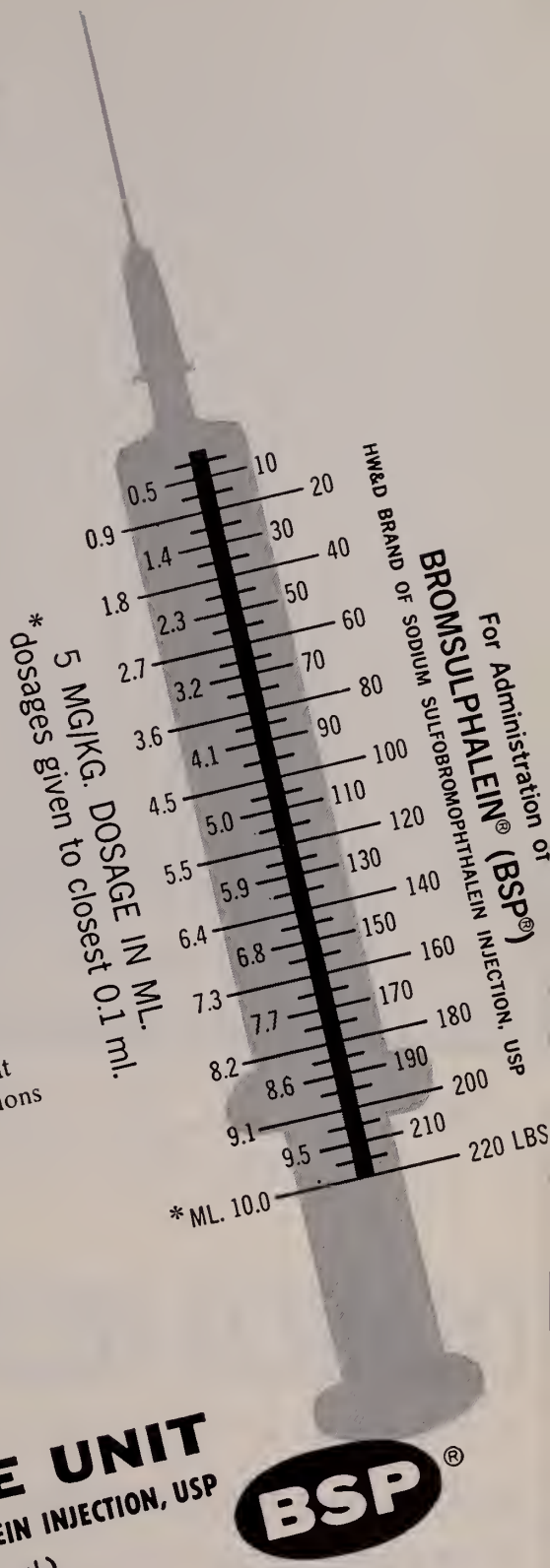
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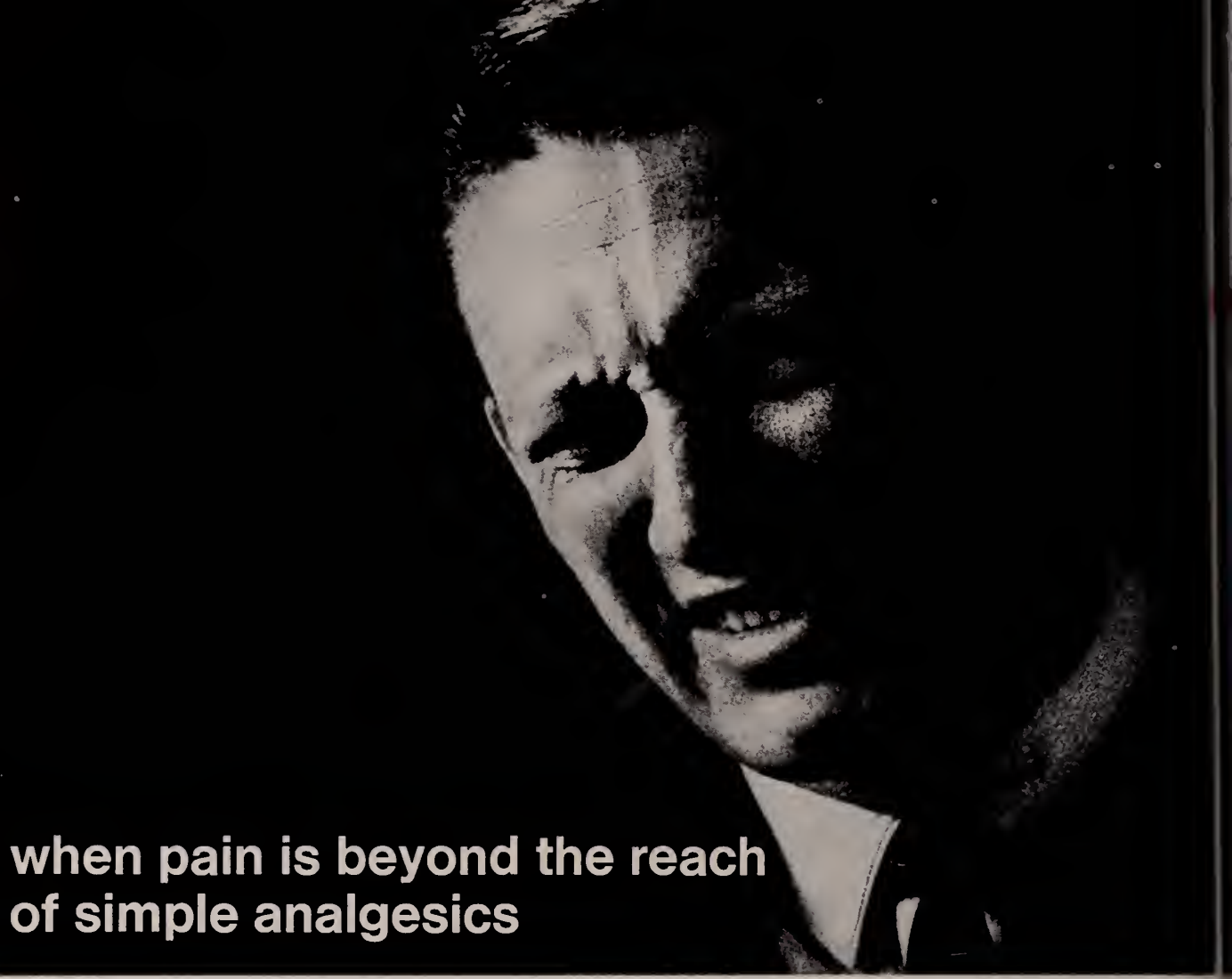
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1. Collective studies, Department of Medical Research, Winthrop Laboratories.

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of the Florida Medical Association

Volume 53, Number 4, April 1966

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nnatal, natural belladonna alkaloids are rationally balanced pecific, fixed ratio that provides "the greatest efficacy with mallest possible dose."[1] They avoid the clinical uncertain- f the variable tincture and extract of belladonna, and are dered superior in range of action to atropine alone.[2] ermore, they are generally recognized as being more effec- han the synthetics for relieving visceral spasm.

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s of clinical use have established phenobarbital as one of nost efficient and highly regarded sedatives. In fact, for ral sedation it is the drug of choice.[3] In Donnatal, pheno- tal potentiates the spasmolytic effects of the belladonna ids, lessening emotional tensions and checking the neuro- impulses that trigger GI disorders.

than 24 indications in PDR

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IN EACH TABLET, CAPSULE, OR (5 cc.) OF ELIXIR

hyoscyamine sulfate	0.1037 mg.
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hyoscine hydrobromide	0.0065 mg.
phenobarbital	(1/4 gr.) 16.2 mg.

(warning: may be habit forming)

IN EACH EXTENTAB

hyoscyamine sulfate	0.3111 mg.
atropine sulfate	0.0582 mg.
hyoscine hydrobromide	0.0195 mg.
phenobarbital	(3/4 gr.) 48.6 mg.

(warning: may be habit forming)

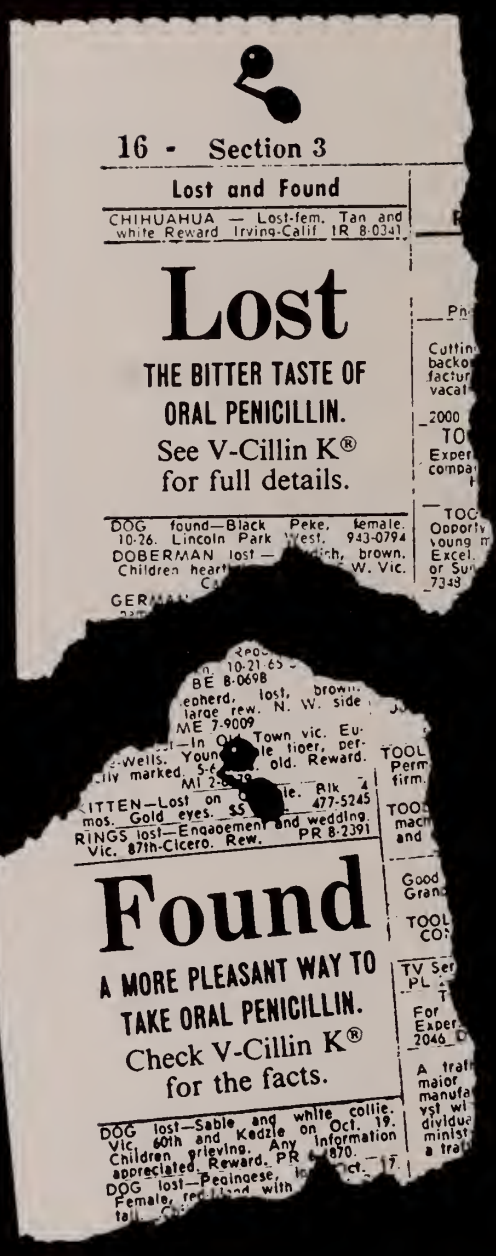
BRIEF SUMMARY: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma, or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease, or a hypersensitivity to any of the ingredients.

REFERENCES: 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

*This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

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Delayed Repair of Large Omphalocele

JAMES W. DICKEY JR., M.D.

Many children are born with congenital anomalies for which, as yet, no satisfactory methods of repair have been developed. Too often, the end result of treatment is a person unable to defend himself against either the forces of nature or his fellow man. If the basic elements of a good citizen are present, however, the challenge of rehabilitation must be accepted without traditional pessimism, or statistical dismay. Children born with an omphalocele present such a challenge and it is encouraging to note an increasingly optimistic and aggressive attitude toward surgical rehabilitation.

The choice between immediate repair and delayed repair is usually decided by the anatomical features present at birth, particularly the diameter of the omphalocele sac. Immediate closure and approximation of the rectus sheaths can be accomplished in those children with a small sac. The larger defects, however, often permit only a temporary covering of herniated viscera with skin undermined and pulled over from the remainder of the trunk. Planning of subsequent operations to restore viscera to normal anatomical position and approximate the rectus muscles also depends largely upon the size of the defect and in particular upon the position of the liver. Retarded development of abdominal parietes has been described[7,2,3] and it has been suggested that further development of the subphrenic fossae will not occur after birth. Retarded development of the subphrenic fossa was noted in a case presented by Handelsman[6] in which attempted replacement of the herniated liver met with failure in a patient one year of age. A subsequent series of surgical procedures to enlarge the subphrenic space began at the age of two and one-half years and was completed with replacement of the liver and viscera at the age of three years.

A similar case of large omphalocele with total displacement of the liver from the abdominal cavity is presented in which replacement of the liver into the subphrenic space was delayed until the child was five years of age, emphasizing utilization of relative growth rates of the liver and body cavities during the first five years of life.

Report of Case

A white male infant was born on May 26, 1955, weighing 5 pounds, 4 ounces. The birth was uncomplicated. Immediately apparent was an intact omphalocele 12 cm. in diameter which contained the entire liver and much of the intestine. Bilateral cryptorchidism was noted, but no other gross defects.

Operation was begun two hours and 20 minutes after birth under open drop ether anesthesia. One hundred cubic centimeters of blood was given through an ankle vein. The skin was incised completely around an edematous sac two centimeters thick. It was considered unwise to attempt covering this mass of sac tissue; therefore, the hepatic sinus, umbilical vessels and urachus were ligated at the edge of the skin and the sac was excised. The liver and much of the intestine had lost "right of domain" in the contracted peritoneal cavity and could not be replaced.

Malrotation of the intestine was noted with the cecum lying free in the right side of the abdomen. Gas was present in both the large and the small bowel.

A layer of skin and fat including Scarpa's fascia was undermined around both flanks to the paraspinal muscles, down to the inguinal ligaments and over the lower half of the chest wall. The rectus muscles could not be approximated because of the position of the liver; so skin was closed over the liver and abdominal contents with 4-0 interrupted subcuticular sutures.

Operating time was one hour and 55 minutes. Recovery was uneventful and the baby was discharged with a healed wound on the twenty-first day, weighing 6 pounds. This bright happy child began walking at the age of 18 months and it was apparent that the abdominal cavity was becoming relatively larger as he developed. The liver could be depressed a short way into the subdiaphragmatic space, but was held by adhesions to the skin and by the costal margins.

The next stage of repair was begun when the child was five years old, stimulated by approaching school age and also by social pressures. He had been suspected of shoplifting and concealing something beneath his shirt. The bulge (fig. 1) was the child's liver, much to the embarrassment of the store detective.

On Nov. 23, 1960, with endotrachial anesthesia, a transverse incision was made beginning 3 cm. lateral to the costal margin over the seventh rib on the right and extending obliquely downward and to the left about 4 cm. past the midline. A plane between the liver capsule and subcutaneous fat was developed and the liver exposed. The liver was lying in a pocket with peritoneum-like lining overlying the rib cage and xyphoid process by a 2 cm. margin. It was rotated so that the inferior surface presented ventrally with the gallbladder lying just beneath and adherent to the skin of the hernial sac. The entire liver was displaced medially and the large right lobe was resting on the vertebral column.

The peritoneal cavity was entered by clearing filmy adhesions from the under surface of the liver, and freeing the liver of all remaining attachments to skin, costal margins and viscera except the vena cava above and a pedicle of hepatic artery, bile ducts, and portal vein below. The stomach and much of the small intestine lay in the left half of the pocket anterior to the costal margins, held by a few fine adhesions. The duodenum was elongated and the cecum was adherent in the right lower portion of the abdomen. The appendix measured 1.5 cm. in diameter and 9 cm. in length. The spleen, pancreas and some small intestine filled the right subphrenic space.

The cecum was freed of adhesions and rotated to the left upper quadrant. Appendectomy and splenectomy were performed, to earn space intraperitoneally. After the viscera occupying the right subcostal space were displaced to the left, the liver would not fit into this space; therefore, the right costal margin was exposed by retracting the rectus muscle to the right, and the overriding peritoneal cavity was retracted to the left. The cartilages between ribs six, seven and eight were cut, allowing the rib cage on the right to be expanded outward in fanlike fashion. The linea alba was then split in the lower abdomen to the pubis allowing the rectus muscle to be retracted more laterally. These two maneuvers increased the right subdiaphragmatic space sufficiently to allow the liver to be rotated down into anatomical position with the large right lobe lateral to the vertebral column. The right rectus sheath was then anchored medially over the liver and the upper right portion of the sac obliterated with interrupted 3-0 Merselene sutures during closure of the transverse incision.

Six hundred cubic centimeters of blood was given during this three hour and 15 minute operation. The boy was returned to the recovery room awake, with nasogastric suction. Recovery was rapid with ambulation and return of bowel sounds the day following the operation. The nasogastric tube was removed and feeding begun. The sutures were removed on the eleventh day and he was discharged on the sixteenth day. Postoperatively, there was noticed bilateral swelling of the scrotum with fluid which could be replaced with pressure back into the peritoneal cavity.

On Feb. 9, 1961, two and one-half months later, the bilateral cryptorchidism and inguinal hernias were repaired with satisfactory replacement of the testes in the scrotum. The child was then observed for five months during which time he wore a snug 4 inch Ace bandage around the abdomen constantly. The ventral hernia could very nearly be reduced when the boy was lying down and relaxed. The rectus muscles had approached the midline during this period.

On August 16, with the patient under general anesthesia, a vertical midline incision was made from xyphoid to midabdomen through the original omphalocele repair scar. Only a few adhesions of viscera to the hernial sac were present. A plane was developed between the peritoneum-like sac lining and subcutaneous fat. The edges of the rectus sheath were exposed bilaterally.

With the child breathing quietly and with the stomach aspirated, the viscera lay at the level of the abdominal musculature. A vertical closure was then begun at the xyphoid level suturing peritoneum and rectus sheaths in one layer with 2-0 Merselene horizontal mattress sutures. The entire wound was closed without undue lateral tension and with no need for plastic reinforcement. Excess



Fig. 1. — The subcutaneous liver is overriding the costal margin and resting on the vertebrae in the midline.

skin was trimmed and sutured lateral to the midline with 3-0 monafilament nylon. He was returned awake to the recovery room with nasogastric suction, sump drains beneath skin flaps, wrapped in Ace bandage, having received 250 cc. of whole blood during the two hour and 30 minute operation. Recovery again was rapid. Gastric suction was discontinued on the second day and he was ambulatory. Discharge was on the sixth day and the sutures were removed on the twelfth day postoperatively. He entered school three weeks after the operation (fig. 2) and his subsequent course has been that of a normal child. He proudly related his exploits on the "monkey bars" at school one month after operation. At the time of this writing he is 10 years old and completely normal as far as function is concerned.

Discussion

Judgment as to the best time for secondary operation to replace herniated viscera in children with a massive omphalocele has varied. Potts[6] suggested that secondary repair should be made within several weeks from birth. Handelsman[3] stated, "It is incumbent upon the surgeon, however, to restore the herniated organs to a more normal position as soon as possible." Holcomb[4] declared, "The time interval between the first and second stages may be as short as three months or as long as six years."



Fig. 2. — Postoperative result with normal chest and abdominal contour.

Obviously, if repair is not difficult and if the liver is not completely displaced, early repair is preferable. In the difficult case, however, consideration of changing body contours and organ size with age would seem to be of great importance in avoiding premature and possibly unsuccessful operation. In normal fetal development, the greatest part of the intestinal canal is within the umbilical cord and by the ninth week of fetal life, Kiebel and Mall[5] stated, "the umbilical hernia is well developed" because of the rapid growth of the liver which crowds the rapidly elongating intestine. Shortly thereafter the intestines slip back through a rather small aperture and remain in the abdominal cavity unless a defect of development occurs. By the thirteenth week, the liver, according to Gray,[1] "almost fills the abdominal cavity." If exteriorized viscera are not within the body cavity by this time the right of domain has been lost and may remain lost until surgical repair has been successfully accomplished.

It is my suggestion that surgical repair may not be successfully accomplished in the massive omphalocele until the ratio of liver size to body cavity size has again become low. Figures to allow comparison of liver and body cavity sizes are not available, but the change in body proportion and contour resulting in loss of infant "pot belly" is usually fairly well advanced by the age of five years at which time replacement of an exteriorized liver and other viscera will in my opinion have a greater chance of success.

The details of surgical repair of an omphalocele have been well documented. In this case, several technical details seem worthy of emphasis. The boundaries of the right subdiaphragmatic space were widened by cutting costal cartilages to allow exaggerated fanlike lateral and anterior expansion of the rib cage. The liver was held out of the subdiaphragmatic space, not so much by pressure of a too small abdominal cavity or underriding of the costal margin, as by medial displacement so that the large right lobe lay on top of the vertebrae. Replacement of the liver was then accomplished by lateral pressure and dorsal rotation to its normal position beneath the diaphragm

where it remained tightly held by normal interosseus and diaphragmatic muscle tension. Permanent expansion of the rib cage by struts or other means was not thought wise since the interosseus muscles could not function and the rectus muscles would be displaced more laterally. Rather, it was thought that the musculature would gradually approach normal position and function if left as undisturbed as possible. This adjustment indeed came about and after an interval of approximately nine months of normal activity and firm Ace bandage compression of the ventral hernia, the rectus muscles had approached the midline and with the child supine and breathing quietly the remaining viscera replaced themselves into the abdominal cavity by gravity.

Conclusion

Following initial repair of omphalocele with displacement of the liver into the sac, if urgent complications do not develop, secondary repair should be deferred until after the age of relative enlargement of the abdominal cavity.

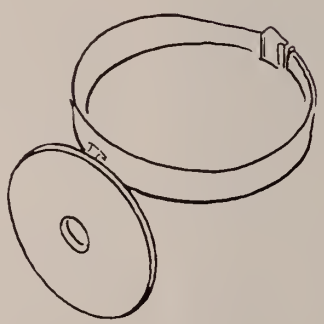
When surgical repair is begun, it is most important to avoid injury to muscles and nerves, since atrophy and contraction of tissues can seriously impair the chances of ultimate restoration of normal relationships.

The use of multiple sectioning of the right costal cartilages to allow exaggeration of the fan-like expansion of the lower rib cage to increase the size of the subphrenic fossa is described.

The recognition of relative rates of growth of the liver, thorax, and abdominal cavity is suggested.

References are available from the author upon request.

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Automated Typing of Autopsy Protocols

EDWARD N. WILLEY, M.D., EDWARD K. MILLER, M.D., and DAN MATEEFF, M.D.

Automation has become commonly accepted in both clinical chemistry and in histology. The automation of autopsy reports, however, has not progressed beyond the use of a typewriter and dictation machine in most pathology laboratories.

The repetitious production of standard autopsy reports is the largest single burden in our anatomical pathology practice. Each year we perform over 1,000 autopsies for the hospital and medical examiner's office and the volume of reports is an exceedingly great burden both on pathologists and secretaries. A method for lightening this burden has been sought for more than a year. For 6 months now we have worked with a standardized autopsy report which has been programed for use on an automatic typewriting machine (fig. 1).* The typewriter has a magnetic tape memory which can be programed so that portions of the memory can be selected and produced on the typewriter at a sustained machine speed of 130 error-free words per minute. New material or deviations from the standard report can be manually entered by the operator wherever the prosector desires to enter information. This utilization of machinery has more than tripled the productivity of a secretary and has at the same time produced a great improvement in the adequacy and usefulness of our autopsy reports. The use of this machine has also lessened the time required for the prosector to dictate each report by approximately one-half hour per case.

The autopsy report is of a narrative type and has three general forms (fig. 2). One report is for adults, one is for children, and another for newborn or premature infants. Weights and measurements are inserted in the appropriate programed normal organ description for the organs examined. The deviations and additions to the standard report are dictated and the provisional diagnosis is given. With the use of this automated technique it now requires five to 10 minutes of the prosector's time to dictate a four or five page single-spaced typewritten gross narrative autopsy report. The finished draft is typed in 20 to 30

*IBM 2 channel magnetic tape typewriter.



Fig. 1.—Typewriter in use producing autopsy protocols.

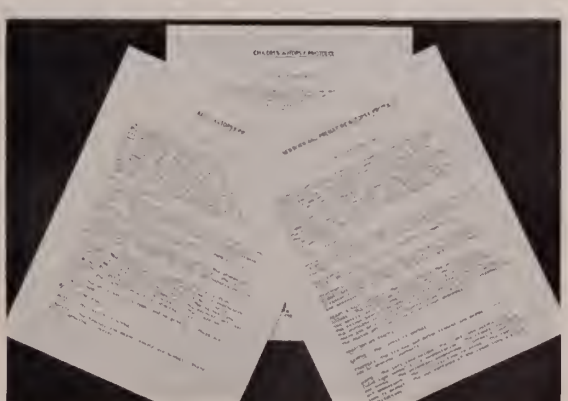


Fig. 2.—Standard autopsy protocols.

minutes of secretarial time. The entire finished gross report is then available within a comparatively short time. There are no omissions of description in routine material and the pathologist is freed from the tedious description of normal organs so that he can devote all of his time to a proper description of significant alterations. In addition, the standardized reports have a degree of uniformity which does away with the problem of reading through an entire report to find a desired description. Even in conference, one can turn to the proper portion of a report with confidence and read an answer to any question.

This automatic typewriter is now used to produce all the autopsy reports for our hospital load. In addition, machine time not used in producing autopsy reports is used to produce mailing lists, multiple original letters, offset press masters, manuscripts, bibliographies, and grant applications. For these uses the automatic typewriter is also ideally suited. For example, a recent grant application which we processed had 20 typewritten pages and passed through 12 revisions in five working days. In this process many insertions and deletions were made and the finished result was letter perfect.

We wish to thank Mrs. Mel Lewis for her assistance and Mr. Bryant English, B.P.A., for making the photographs.

▶ Drs. Willey, Miller and Mateeff, Duval Medical Center, 2000 Jefferson Street, Jacksonville 32206

Archives Committee Requests Data

The FMA Archives Committee is trying to collect data from which to write a history of medicine in Florida. If you have in your possession books, pamphlets, reprints, manuscripts, newspaper clippings or photographs that would aid in this project and which you are willing to loan, please bring them with you to the May 12-15 FMA Annual Meeting. Word may be left at the Registration Desk and Dr. William Straight, chairman of the Archives Committee, will arrange to meet with you to obtain the material.

Brain Scans and Subdural Hematomas

SHELDON B. MEYERSON, M.D., GARY S. WALTERS, M.D., and DAVID H. REYNOLDS, M.D.

During the last few years brain scans have been shown in many reports in the literature to have definite value in the detection, localization and postoperative follow-up of brain tumors. Only scattered references have been made to small numbers of patients with regard to detecting space-occupying lesions following trauma to the head.

Afifi et al.,[1] who recently reported scanning 450 patients for possible neoplasms, obtained positive scans in three out of four patients with subdural hematomas. The one hematoma that was missed by the scan was bilateral. Planiol[2] in 1961 reported in his series of 340 patients which was concerned primarily with tumors, that there were 20 hematomas, 13 of which were positive by scan. One subdural hygroma also was not detected on the scan. Brinkman et al.[3] reported in 1962 finding two subdural hematomas in a series of 92 patients scanned for tumor detection. Sweet and Brownell[4] reported four subdural hematomas in a series of 250 patients with two positives and two negatives.

Gilson and Gargano[5] recently completed a paper compiling results of brain scans in a series of 73 patients, who were admitted over a period of 14 months for acute head trauma and findings suggestive of an intracranial lesion. In 28 patients increased isotope pickup suggested a localized lesion. Six of these patients improved rapidly, did not require arteriography and were discharged with the presumed diagnosis of contusion. Eighteen of these patients were subsequently operated on after angiography confirmed the presence of a lesion. There were two false positives, with apparent lesions on the scan and negative arteriograms.

In this paper the operative findings are compared with the findings on preoperative brain scans in order to evaluate the diagnostic accuracy in detecting this particular lesion. Echoencephalograms have recently come into use in this hospital as an additional diagnostic procedure. They have been helpful in determining the presence of a midline shift. Some of the patients who had brain scans also had an echoencephalogram and these results are mentioned.

Method and Material

The scanning equipment used at this institution in the majority of cases is the Nuclear-Chicago Pho-dot Scanner, utilizing a 19 hole collimater. Mercury-203 Neohydrin was used in adults, and Mercury-197 Neohydrin in patients under 16 years of age to reduce the amount of total body and renal radiations in the younger age group. A renal blocking dose of 1 cc. Mercuhydrin is given. Scanning follows the injection of radioisotope by two hours. Two projections usually are taken, an anteroposterior and a lateral. If localizing signs are present, this plan is altered appropriately.

The operating room records were reviewed for a period of 18 months. All patients with subdural hematomas found at operation, whether alone or concomitantly with contused brain or intracerebral hematoma, were collected for this study.

From the Division of Neurosurgery, Department of Surgery, University of Miami School of Medicine, and Jackson Memorial Hospital, Miami, Fla.

Read before the Florida Neurosurgical Society, Miami, Fla., Jan. 22, 1965.

Results

During the 18 month period, July 1963 to January 1965, 66 patients were operated on who had subdural hematoma as the sole or partial diagnosis. The majority of these patients required immediate arteriography and operation; therefore, only 22 had brain scans as part of the preoperative work-up. Of these, 19 were reported positive for subdural hematoma, one was reported as a contusion and two were reported negative. Review of the cases with reported negative scans is worthwhile and these cases are briefly presented.

Report of Cases

Case 1.—The patient was admitted to the hospital at the age of five months with a history of known head trauma. He was somewhat drowsy and lethargic on admission, with bulging fontanelles. Subdural taps revealed the presence of bilateral subdural hematomas. He was eventually subjected to staged craniotomies and bilateral subdural hematomas were removed. The brain scan (fig. 1) was reported negative, but there was questionable increased pickup bilaterally in the anteroposterior view along the convexities.

Case 2.—A 42 year old white woman was admitted with a history of sudden onset of headache, generalized seizures, pain in the left eye, and loss of consciousness. She was disoriented, had a subhyoid hemorrhage and diminished vision on the left, and bilateral extensor plantar response. Arteriograms were suggestive of a left temporal lobe mass lesion, most likely hematoma. No definite aneurysms were noted, although there was a double density along the course of the main middle cerebral artery. At operation a left temporal intracerebral hematoma and a small left frontotemporal subdural hematoma were found. The trunk of the middle cerebral artery was widened and thickened and was suspect for aneurysm. Subsequent arteriography revealed an aneurysm of the left internal carotid artery, which was successfully treated. The brain scan (fig. 2) was reported negative.

Case 3.—A 79 year old Negro man had a history of head injury and left hemiparesis. Carotid arteriograms were consistent with a right frontotemporoparietal hematoma. At operation a chronic right frontotemporoparietal subdural hematoma was found. Reviews of the brain scan (fig. 3) revealed an oval circumscribed area of density approximately 3 by 6 cm. in size at the base of the right frontal lobe, just anterior to the Sylvian fissure. This was read to be compatible with a brain contusion.

One of the two patients with scans reported negative had a bilateral subdural hematoma which is often difficult to diagnose by scan, and

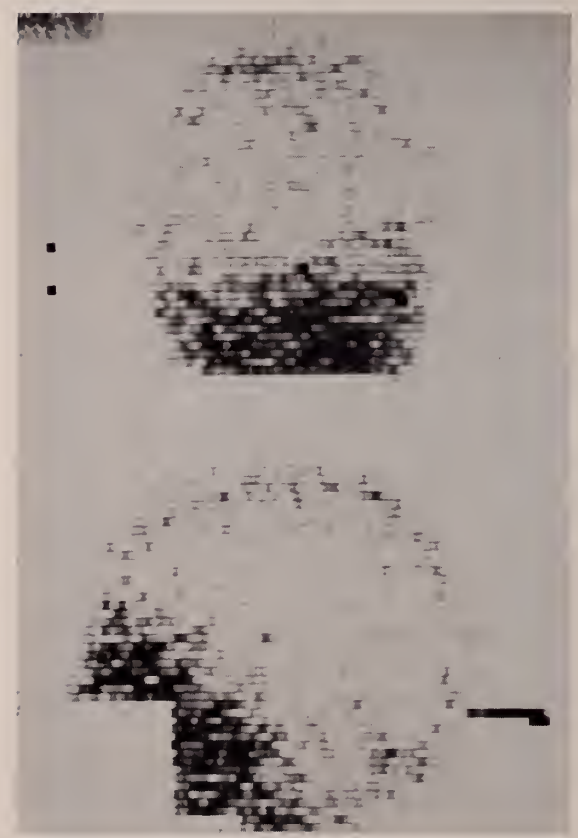


Fig. 1. — Bilateral subdural hematomas in an infant. Brain scan was reported negative.

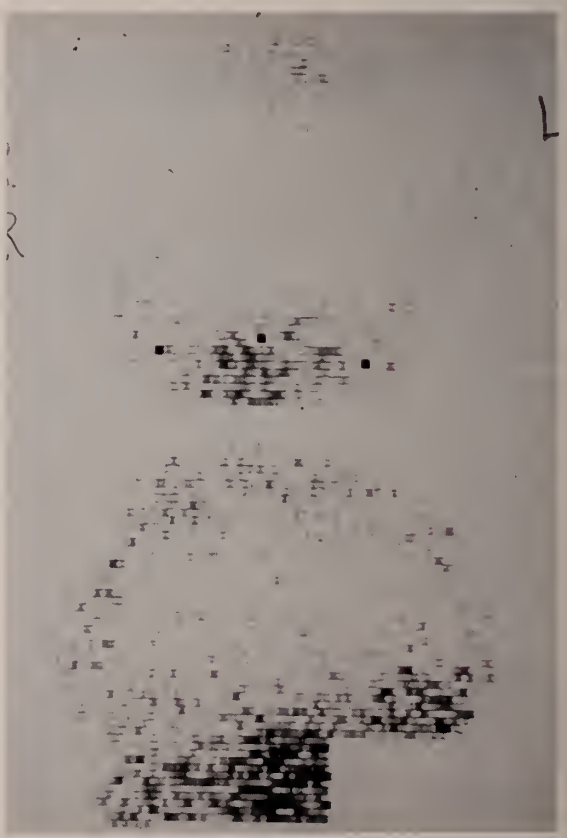


Fig. 2. — Left temporal lobe intracerebral hematoma with small subdural hematoma. Brain scan was reported negative.

the other had a predominant intracerebral and only a small subdural hematoma.

Five echoencephalograms were performed on the patients who were scanned. Four were reported as negative for a midline shift and one was positive for a midline shift in the appropriate direction.

Discussion

The typical pattern of uptake absorbed by the subdural hematoma is illustrated in figure 4. The most important view in subdural hematomas is the anteroposterior view, which reveals increased uptake over the convexity, sometimes in a crescent shape. The lateral view may appear normal or show an increased uptake, but without localization. Bilateral subdural hematomas are often difficult to read because the increase in uptake is symmetrical. They may, however, demonstrate bilateral crescentic thickenings, as in figure 5.

These patterns may be distinguished from those of cerebral contusions or intracerebral hematomas. A contusion presents as a more circumscribed area of increased uptake, both on the anteroposterior and lateral view. Intracerebral hematoma, as seen in figure 6, is also more localized than subdural hematomas on the lateral view and on the anteroposterior view, the pickup is much deeper in the hemisphere.

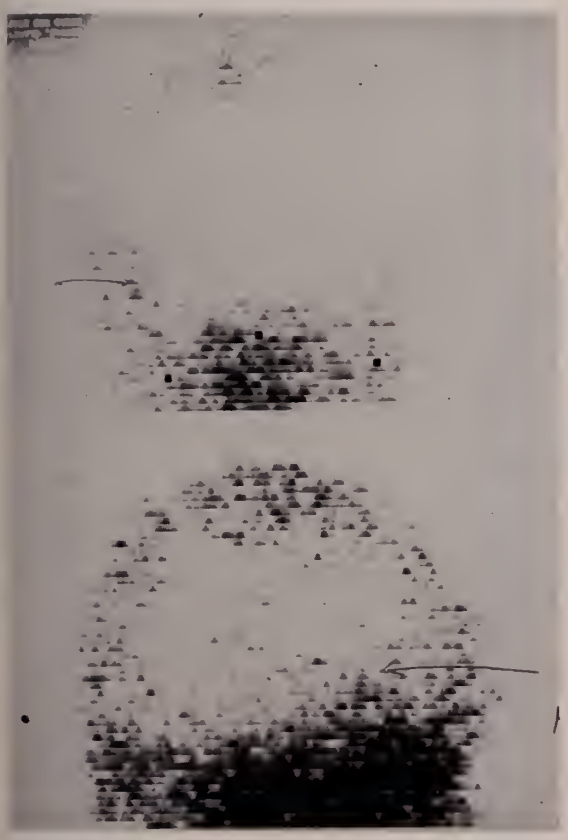


Fig. 3. — Chronic right subdural hematoma. Brain scan was reported as compatible with cerebral contusion.

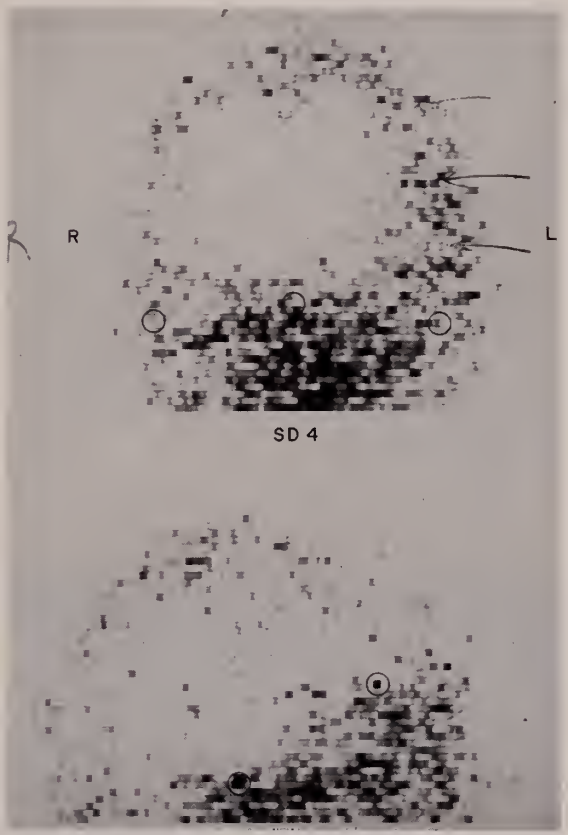


Fig. 4. — Typical pattern of uptake with subdural hematoma.



Fig. 5. — Pattern of uptake with bilateral subdural hematoma.

The site of isotope uptake in subdural hematoma has been a matter of discussion. Brinkman et al.[3] stated that the common denominator for increased uptake seems to be new blood vessel formation. Mealey[6] performed a study in dogs with experimental subdural hematomas and found that the isotope tends to concentrate in the membranes, particularly those that are well developed and well vascularized. The isotopes apparently passed from the vessels in the dura to the adherent outer membranes. Increased isotope concentration was present to a much lesser degree in the subjacent cerebral cortex as compared to the normal cortex. The clinical significance of this finding was not thought to be great. They stated, therefore, that chronic subdural hematomas with thickened membranes are the lesions best suited for diagnosis by brain scan. These conclusions are somewhat questioned by the fact that some proved subdural hematomas with positive scans have been found to have no membranes and also that some postoperative scans have shown persistence of increased uptake.



Fig. 6.—Pattern of uptake with intracerebral hematoma.

The value of brain scans as a diagnostic tool for the detection of subdural hematomas is emphasized by the finding of only two false negative scans in the series presented. One, as noted, was in an infant with bilateral disease and the other in a patient with a small subdural hematoma and an intracerebral hematoma. The other factors adding to the usefulness of the scan are its simplicity, safety, and the rarity of false positive scans. The scan has been of greatest value in managing those patients with suspected subacute or chronic subdural hematomas, in whom the findings did not seem to warrant the use of angiography or air studies. Its use in patients with possible acute subdural hematomas is limited by the time factor for those patients could not be subjected to the necessary delay of obtaining a scan.

Summary

The literature concerned with brain scans and subdural hematomas is reviewed. A number of authors, scanning a total of 1,132 patients for possible neoplasm, reported a total of 30 patients with subdural hematomas, 20 of whom had positive brain scans. One author, evaluating brain scans in patients with head trauma, and subdural hematomas, reported only two false positives.

A series of 64 patients with known subdural hematomas is analyzed and correlated with the number of positive and negative brain scans. Nineteen scans were reported positive, one was reported contusion and two were reported negative.

The cases with negative brain scans are reported and discussed. One patient had a bilateral subdural hematoma and one had a small subdural hematoma with an intracerebral hematoma.

The patterns of unilateral and bilateral subdural hematomas, cerebral contusion and intracerebral hematoma are described. Unilateral subdural hematomas usually produce a crescent-shaped area of increased uptake over the involved convexity on the anteroposterior view. Bilateral subdural hematomas cause bilateral thickening and are often difficult to diagnose because of the

symmetrical uptake. Cerebral contusion and intracerebral hematoma are both more circumscribed on the anteroposterior and lateral view than is the subdural hematoma.

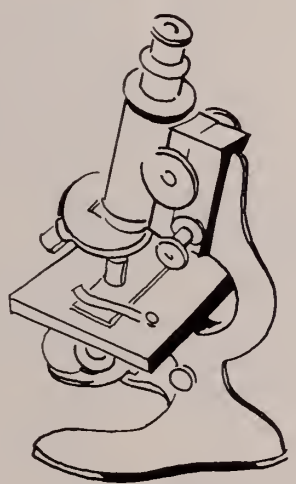
The site of increased isotope pickup and the type of subdural hematoma best suited to diagnosis are discussed. Well developed and well vascularized membranes are the site of increased isotope pickup, and thus chronic subdural hematomas, with thickened membranes, are more readily diagnosed with the brain scans.

The importance of brain scans as a screening diagnostic study in the detection and management of those patients with suspected subdural hematomas is stressed. Emphasizing this point is the finding in our series that only two brain scans were definitely false negative.

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▶ Dr. Reynolds, 1701 Espanola Drive, Miami 33145



Clinical Correlation Conference

Jaundice: Metabolic Physiologic And Pathologic Considerations

Chairman: Arvey I. Rogers, M.D., Instructor in Medicine; Chief, Gastroenterology, Veterans Administration Hospital, Coral Gables.

Moderator: Martin H. Kalser, M.D., Professor of Medicine and Physiology; Chief, Division of Gastroenterology, Jackson Memorial Hospital, Miami.

Participants: Donald Harkness, M.D., Assistant Professor of Medicine, Department of Research Hematology.
Paul Hilf, M.D., Clinical Instructor, Department of Medicine.
Arthur Gilbert, M.D., Clinical Instructor, Department of Surgery.

I. Hemoglobin Metabolism

Dr. Harkness.—Jaundice as a manifestation of liver disease was recognized by Hippocrates, and Galen observed its association with gallstones. The concept that bile pigment is derived from blood pigment is also probably quite old. Virchow showed this experimentally by recovering bilirubin crystals from old hematomas. Emil Fischer proved the chemical similarities of these pigments showing them to be tetrapyrroles. More recent investigations have shed considerable light on details of this conversion of heme, the protoporphyrin 9-ferrous iron complex prosthetic group of hemoglobin, to bilirubin.

Though there are other heme-containing proteins in the body including myoglobin, cytochrome c, carbonic anhydrase, and catalase, it is estimated that 80 to 95% of bilirubin formed is derived from hemoglobin. Senescent red cells, after a normal circulating life span of about 120 days, are engulfed by cells of the reticuloendothelial system where the globin is presumably degraded and its amino acids returned to the body pool for reutilization. The iron is extracted and either immediately used or stored as the ferric hydroxide, hemosiderin, or in association with the protein, apoferritin, as ferritin.

Only the porphyrin moiety of hemoglobin is irretrievable to the organism, being mostly converted to bilirubin and excreted in the bile. The details of this conversion are not entirely clear

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One of a series of clinical correlation conferences on "Symptoms" presented to Junior and Senior Medical Students at Jackson Memorial Hospital, Miami.

University of Miami School of Medicine

and several pathways have been proposed. It is agreed that free biliverdin is eventually formed and an enzyme system in the liver has been described capable of reducing biliverdin to bilirubin. Controversy has centered around whether or not cleavage at the α-methenyl carbon takes place while the heme is still bound to the globin and whether the iron must still be present for this oxidation (fig. 1).

Early investigators thought heme was first removed from the protein, the iron oxidized forming the compound hematin, and then the iron extracted leaving free protoporphyrin 9. Rats, however, given ^{14}C-labeled protoporphyrin 9 fail to excrete significant amounts of labeled bilirubin. Hematin itself can be converted to bilirubin, but there is no evidence that it is an obligate intermediate in heme catabolism. These observations have given rise to speculation that iron must be present for ring cleavage. Next choleglobin, a green pigment attached to globin, was described and advanced as a possible intermediate though its structure was never fully discerned.

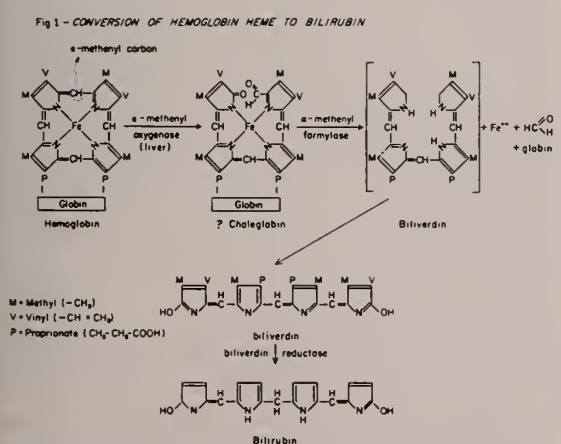


Fig. 1. — Scheme for degradation of hemoglobin to bilirubin.

Recently Japanese investigators have described in liver an enzyme, α-methenyl oxygenase, which oxidizes the α-methenyl carbon of heme, forming a green globin-bound, iron-containing linear tetrapyrrole with a terminal formyl group. A second enzyme removes the formyl group giving rise to free biliverdin, ferrous iron, globin, and formaldehyde. One very interesting property of this enzyme system is its substrate specificity. Free hemoglobin itself is not a substrate, but when bound to haptoglobin, the hemoglobin-complexing protein in serum, becomes an excellent substrate. This may prove to be the physiologic role of haptoglobin.

The scheme represented in figure 1 is an attempt to present a coherent description of the conversion of heme to bilirubin, consistent with most experimental results. Until the identity of each intermediate has been definitely established, this scheme should be considered only tentative. It should also be remembered that since all heme injected into experimental animals is not recovered as bilirubin, there may be alternate pathways for degrading heme.

Brief mention should also be made about another area of speculation in bilirubin formation. When N^{15}glycine is injected into animals, some heavy isotope appears in fecal stercobilin within a few days, well before appearing in the heme of circulating erythrocytes. After about a week the isotope in fecal stercobilin falls to a low level, not rising again until around 90 to 120 days when the effete red cells are removed from the circulation.

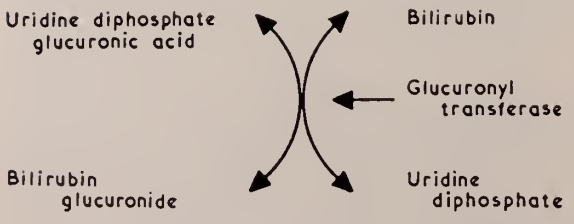
Normally about 10% of the injected isotope ultimately recovered as stercobilin is excreted early; in some disease states such as porphyria and pernicious anemia, this may approach 40 to 50%.

Various theories advanced to explain these findings include: (1) heme in excess of globin is synthesized in reticulocytes, is degraded, and excreted in the bile; (2) intracorpuscular degradation of hemoglobin takes place during red cell maturation; (3) destruction of newly formed erythrocytes occurs before they leave the bone marrow; (4) direct synthesis of pyrroles or bilirubin; (5) more rapid turnover of heme in other heme proteins. Generally speaking, the first three mechanisms are considered most likely. Another possible explanation similar to (2) has been suggested by recent studies showing hemoglobin synthesis in the nucleus of duck and rabbit erythrocytes. Were this to prove of significant proportions, this early labeling of stercobilin could also arise from this nuclear hemoglobin which presents itself for catabolism at the time of nuclear extrusion.

II. Bilirubin: Conjugation and Excretion

Dr. Rogers.—Once bilirubin has been formed by the degradation of hemoglobin in the reticuloendothelial cells of the liver, spleen and possibly lungs, it is attached to albumin, solely and firmly, circulates in this bound form (unconjugated) to the liver where, through the assistance of a microsomal enzyme, glucuronyl transferase, becomes conjugated to glucuronide and, in the conjugated form, is excreted into the intrahepatic biliary canalicular system and, finally, the extrahepatic biliary tract leading to the gut (fig. 2).

Certain aspects of this process of conjugation and excretion are not well defined. For instance, it is not known how the bilirubin, bound to albumin, gets into the hepatic parenchymal cell; that is to say, whether the bound form crosses the sinusoidal-liver cell membrane barrier, or whether the bilirubin is released from the complex prior to transmucosal transport. Studies utilizing tritiated (H3) bilirubin would suggest that the bilirubin-albumin complex becomes separated prior to bilirubin entering the liver cell. Other evidences in favor of complex breakdown may be found in the studies utilizing guinea-pig fetal circulation still in contact with maternal placental circulation. Injection of I^{131}-tagged albumin-bilirubin into the fetal circulation resulted in the appearance of the bilirubin in the maternal circulation attached to untagged protein. These studies would suggest that the albumin-bilirubin complex cannot cross membranes as such.



The conjugation of bilirubin by the liver as a glucuronide.

Fig. 2. — Scheme depicting bilirubin conjugation to glucuronide and source of glucuronide.

Once the free (unconjugated) bilirubin gains access to the hepatic parenchymal cell, conjugation with glucuronide proceeds to the end-product of bilirubin-diglucuronide. Analysis of bile in normal humans and animals does not reveal free bilirubin and only the conjugated complex is found.

A strain of Wistar rats (Gunn rats-homozygous), congenitally lacking glucuronyl transferase, is severely jaundiced with indirect (unconjugated) hyperbilirubinemia. When these rats are injected intravenously with already conjugated bilirubin, they demonstrate a normal transport maximum for the conjugated product, indicating that the processes of bilirubin conjugation and excretion are independent ones.

How the conjugated product gains access into the biliary canalicular system is unknown, but the mechanism is probably related to active transport and is dependent upon structurally normal microvilli lining the biliary canaliculi. Pathologic states in man associated with high bilirubin (conjugated) and high alkaline phosphatase values in the serum are frequently associated with ultramicroscopic changes in the microvilli lining the biliary canaliculi. There is always some question as to whether these changes are related to cause or effect.

III. Congenital Hyperbilirubinemina States (Table 1)

Dr. Rogers.—Man may be afflicted by congenital defects in the processes regulating bilirubin transport, conjugation and excretion so that

Table 1.—Congenital Hyperbilirubinemias

I. Infant (all unconjugated varieties)
   1. Neonatal "physiologic" jaundice—immature enzyme system.
   2. Crigler-Najjar syndrome—lack of enzyme system.
   3. Lucey-Driscoll syndrome—inhibition of enzyme system by serum.
   4. Breast milk jaundice (observed only in breast-fed children)—inhibition of enzyme system by factor in milk.

II. Adult
   1. Gilbert's syndrome—unconjugated; two varieties (mild, severe); related to incompletely developed enzyme system and/or transport defects.
   2. Dubin-Johnson syndrome—conjugated; liver pigment; benign; high alkaline phosphatase; nonvisualizing biliary system.
   3. Rotor syndrome—conjugated; no pigment; benign; normal alkaline phosphatase; less difficulty visualizing biliary system.

hyperbilirubinemia of the unconjugated or conjugated varieties may occur. These defects may first manifest themselves in the infant or not become apparent until adulthood. They may be severe and cause death, or they may be mild. The disorders of bilirubin metabolism affecting infants are: (1) "physiologic" jaundice of the newborn; (2) Crigler-Najjar syndrome; (3) Lucey-Driscoll syndrome; and (4) jaundice due to an inhibitory factor in breast milk observed exclusively in breast-fed infants. The conditions observed in the adult are: (1) Gilbert's syndrome —constitutional hepatic dysfunction; (2) Dubin-Johnson syndrome; and (3) Rotor syndrome.

Physiologic Jaundice of the Newborn.—This condition is encountered in practically all full term neonates, makes its appearance several days following birth, usually subsides within a week to 10 days, is moderate in intensity, is never associated with kernicterus, and is thought to be related to an immaturity of the glucuronyl transferase system (which usually matures within several days to two weeks following birth). Kernicterus may occur in the premature infant with "physiologic" jaundice. The tendency for kernicterus to develop may be increased by the occurrence of infection and starvation, as well as by the administration of sulfadiazine, sulfisoxazole, (Gantrisin), and salicylates to the infant. The drugs mentioned seem to compete with unconjugated bilirubin for binding sites on albumin. The administration of vitamin K, or its analogues, to a newborn infant or the mother prior to delivery has been associated with the unexpected development of kernicterus.

Crigler-Najjar Syndrome.—This is a chronic form of jaundice associated with defective conjugation of bilirubin, observed familially, and usually associated with damage to the central nervous system. Less than 25 cases have been described, including the original description by Crigler and Najjar in 1952. An interesting study model has been found in the mutant strain of Wistar rats, congenitally lacking glucuronyl transferase. In vivo and in vitro studies in humans have suggested that reduced glucuronide formation is responsible for the primary excretory defect of bilirubin observed. If the infant does not die within the first year of life, he may survive with a constant level of elevated unconjugated bilirubin. Alternate pathways of pigment excretion balance the rate of pigment formation and a so-called "steady-state" is reached.

Lucey-Driscoll Syndrome.—This condition is known as transient familial neonatal hyperbilirubinemia and was described in 1960. It is observed several hours after birth, is unrelated to breast feeding, occurs in most related siblings, is characterized by bilirubin levels ranging from 25 to 65 mg. per 100 ml. during the first few days of life and may be associated with kernicterus. Mothers of infants with this syndrome are found to have an unidentified substance or substances in high titer in their plasma which is (or are) capable of inhibiting glucuronyl transferase activity in vitro.

Breast Milk Jaundice.— Prolonged neonatal jaundice associated with breast feeding has been known since 1861 and written about extensively since 1963 by Arias and his group in New York. The syndrome has been described more extensively in a recent paper by Arias and his associates, in which seven unrelated full term infants were studied. The unconjugated hyperbilirubinemia observed in these infants was minimal during the first five days of life and severe icterus did not become apparent until the seventh to tenth days. Signs and symptoms of kernicterus were not observed, despite the fact that levels of unconjugated bilirubin reached 14.7 to 24.5 mg. per 100 ml., and this finding was probably related to the maturity (or impermeability) of the blood-brain barrier to unconjugated bilirubin. Eliminating breast feeding resulted in disappearance of the jaundice. Milk obtained from the

mothers of the seven infants consistently inhibited glucuronyl transferase activity in vitro, whereas that obtained from 71 women whose infants did not demonstrate this syndrome did not inhibit glucuronyl transferase activity to any appreciable or consistent degree.

Gilbert's Syndrome.—This condition is characterized by mild, usually asymptomatic unconjugated (indirect) hyperbilirubinemia in the adult population and probably represents a heterogeneous group of benign disorders. It may appear as a sequel to infectious hepatitis or in a patient with a family history of benign icterus. The condition is probably not due to a conjugating defect in terms of a deficient or inhibited glucuronyl transferase system and is more likely related to a defect in transport of free bilirubin across sinusoidal or hepatic membranes. Liver biopsy specimens are usually normal on light microscopy.

Dubin-Johnson Syndrome.—Jaundice occurring in this condition and the Rotor syndrome is almost entirely of the conjugated, or direct, variety. This condition is often familial, and the liver is characteristically greenish black on gross appearance. The patients may have pain in the right upper abdominal quadrant and elevated alkaline phosphatase values and may have difficulty excreting contrast material used for cholangiography. The bromsulphalein (BSP) excretion curve is characteristic in retaining less than 20% of the injected dye at 45 minutes and having 50 to 60% retention at 120 minutes and is probably related to regurgitation of the conjugated product. The liver contains excess lipofuscin pigment microscopically and is otherwise normal.

Rotor Syndrome.—This condition is very much like the Dubin-Johnson syndrome with the exception that the liver is not pigmented, the alkaline phosphatase values are usually normal, and there is not too much difficulty in excreting contrast material into the biliary tree. The BSP curve reveals a retention of 50 to 60% at 45 minutes and the same at 120 minutes.

I have tried to present a brief review of current thoughts on the metabolism of bilirubin and, by necessity, have had to omit details of the many excellent studies which have allowed us to reach our present, somewhat sophisticated, state of knowledge concerning this major end-product of red blood cell metabolism. I hope that this review has made it possible for you to understand the mechanism of some of the more interesting congenital defects in bilirubin metabolism and will stimulate you into further reading in this area.

IV. Jaundice: Diagnosis

Dr. Hilf.—The History: Usually with a thorough, careful history and physical examination, the cause of jaundice can be identified in four out of five cases. Since hemolytic jaundice is easy to recognize, the major problem is to determine if jaundice is due to hepatocellular or obstructive factors. I shall try to summarize my approach in making this distinction in the history and examination of a jaundiced patient.

The possibility of infectious or serum hepatitis can be excluded by inquiring about exposure to jaundiced persons, recent blood transfusion, and parenteral injections. Exposure to these suggests viral hepatitis. A previous attack of hepatitis would usually give immunity to infectious hepatitis but not to the serum variety. With a history of familial jaundice you should consider Gilbert's syndrome, Dubin-Johnson and Rotor syndromes, and chronic intrahepatic cholestasis. Jaundice is usually mild, and chronic, and tends to become more severe with infection, fatigue and alcohol intake. A history of excessive alcohol intake with poor dietary intake suggests alcoholic hepatitis, fatty liver and cirrhosis.

Drug-induced jaundice must always be considered seriously in every patient since so many drugs currently being used can produce jaundice, especially when eosinophilia, rash and arthralgia are present. Remember that dosage and duration of treatment are unrelated usually. Some of the more commonly associated drugs include the phenothiazines, 17$^{\alpha}$-alkylated testosterones, certain antidiabetic agents, tranquilizers and antibiotics.

Abdominal pain may occasionally be a helpful clue. It is not a prominent symptom in viral hepatitis or cirrhosis although it may be severe in the acute fatty liver of the alcoholic. It is prominent, however, in patients with primary cancer of the liver and frequently with metastatic cancer. In patients with common duct stones it is usually colicky and accompanied by nausea and vomiting, may not be confined to

Table 2.—Laboratory Tests in Jaundice

Test	Type of Jaundice	
	Parenchymal	Obstructive
1. Bilirubin, total	<10 mg.%	>10 mg.%
2. Alkaline phosphatase	<6 BU*	>10 BU
3. Prothrombin time (%)	Abnormal	Usually normal**
4. Cephalin flocculation (48 hr.)	2-4+	Negative-1+
5. Thymol turbidity	>6 units	<4 units
6. SGOT or SGPT	>250 units	<250 units
7. Serum albumin	Low (<3.0 gm.%)	Normal (>3.0 gm.%)
8. Serum globulin	High	Normal

*Bodansky units (normal up to 4).
**When abnormal, may revert to normal following systemic administration of a vitamin K analogue.

the right upper quadrant, but may be located in the epigastrium as well. In most patients with pancreatic cancer, the pain is usually epigastric with radiation to the back, may be aggravated by lying on the back and relieved by lying prone, by lying on the side with knees flexed, or by sitting up and bending forward. The pain of pancreatic carcinoma may precede the onset of jaundice.

Chills and fever generally indicate cholangitis, which suggests a common duct stone, but may occasionally occur in viral hepatitis, thorazine jaundice and fatty liver. Dark urine indicates the onset of jaundice and may precede skin and scleral discoloration by several days. Clay-colored stools occur in the early obstructive phase of viral hepatitis; in common duct stone they may be intermittently acholic and in neoplastic jaundice, they usually remain acholic.

Physical Examination.—Examine the patient carefully for peripheral cutaneous signs of liver disease, particularly vascular spiders, palmar erythema and xanthomata. Also look for parotid swelling, clubbing, collateral veins and ascites. When you examine the abdomen, give particular attention to the liver, gallbladder and spleen.

A firm nodular liver is characteristic in metastasis, but may occur in postnecrotic cirrhosis, cystic disease of the liver, fatty liver and even tuberculosis and sarcoid. The absence of an enlarged liver in a patient with obstructive jaundice tends to exclude neoplastic obstruction of the common bile duct. In hepatitis the liver is usually slightly enlarged and tender and a very large liver is frequent with fatty liver, cirrhosis, tumor, congestive failure and amyloidosis. A friction rub over the liver frequently can be heard over a metastatic nodule and a bruit in a patient with portal hypertension. A distended palpable gallbladder indicates obstructive jaundice usually of neoplastic origin. A palpable spleen is seen in 15% of patients with hepatitis and about 50% of patients with cirrhosis, and may be observed as well in the patient with malignant invasion of the portal venous system.

Ascites usually indicates cirrhosis, but may also occur with massive necrosis, peritoneal tumor seeding, tuberculous peritonitis, and portal vein invasion by cancer.

Use of Liver Profile and Other Tests.—To help confirm your clinical impression appropriate laboratory tests can be made which might help distinguish hepatocellular (intrahepatic) from obstructive jaundice. These include serum bilirubin, transaminase, alkaline phosphatase, serum albumin and globulin, thymol turbidity, cholesterol and flocculation tests (table 2).

Differential Diagnosis.—A major problem which frequently arises is to differentiate intrahepatic cholestasis (that is, clinical and biochemical evidence of obstructive jaundice with patency of the extrahepatic ducts) from true extrahepatic obstruction. The syndrome of intrahepatic cholestasis has many etiologies. It may be associated with drugs, the last trimester of pregnancy, viral hepatitis, the acute fatty liver of the alcoholic, and occasionally postnecrotic cirrhosis (table 3).

If the results of liver function are equivocal and are unchanged or worsening after 10 days of observation, then you can evaluate the response

Table 3.—Intrahepatic Cholestasis

1. Drug-induced (phenothiazines, 17-alpha alkylated steroids, etc.)
2. Cholangiolytic hepatitis (virus).
3. Fatty liver of alcoholic.
4. Obstructive jaundice of pregnancy.
5. Benign recurrent intrahepatic cholestasis.
6. Postnecrotic cirrhosis.

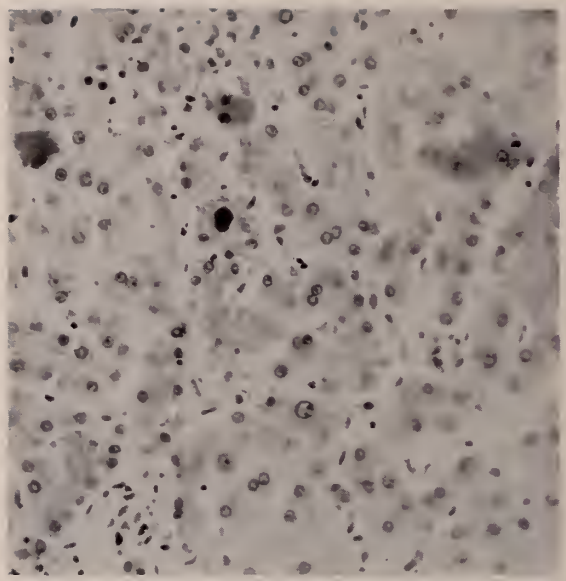


Fig. 3. — Extrahepatic obstruction with single large bile infarct and staining of cells with bilirubin. Also note varying degrees and cellular activity and small canalicular bile plugs.

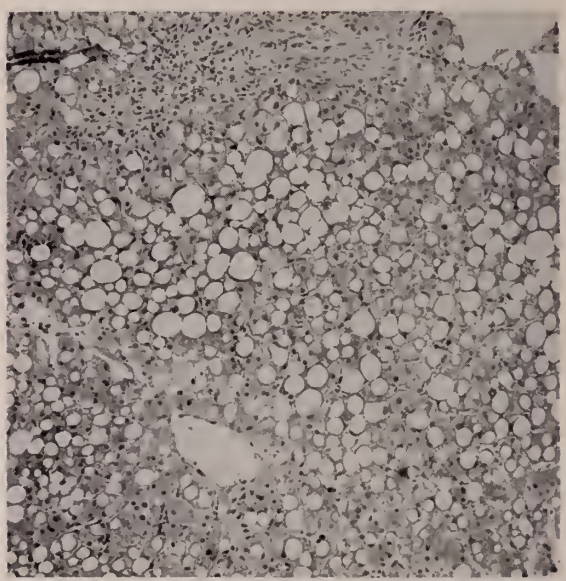


Fig. 4. — Severe fatty metamorphosis with normal central vein and cellular portal tract with minimal fibrosis.

of the serum bilirubin concentration to prednisone (40 to 60 mg. daily for four to six days) administration. If the bilirubin concentration decreases by 50% or more during this time, hepatocellular jaundice is more likely. If the diagnosis is still doubtful, you should consider liver biopsy and percutaneous transhepatic cholangiography, if the platelet count and prothrombin times do not contraindicate their performance (platelet more than 100,000 cu. mm.; prothrombin time more than 50% of normal).

The finding on liver biopsy of inspissated bile in interlobular bile ducts, extravasated bile in portal tracts, bile infarcts, or bile lakes is pathognomonic of extrahepatic cholestasis (fig. 3). Fatty metamorphosis, hepatic carcinoma, or pericholangitis may be discovered as well (figs. 4-6).

Failure to puncture a dilated bile duct with transhepatic cholangiography is strong evidence that the jaundice is not due to mechanical obstruction of the large bile ducts. If a duct is aspirated, operation should follow in a few hours (fig. 7).

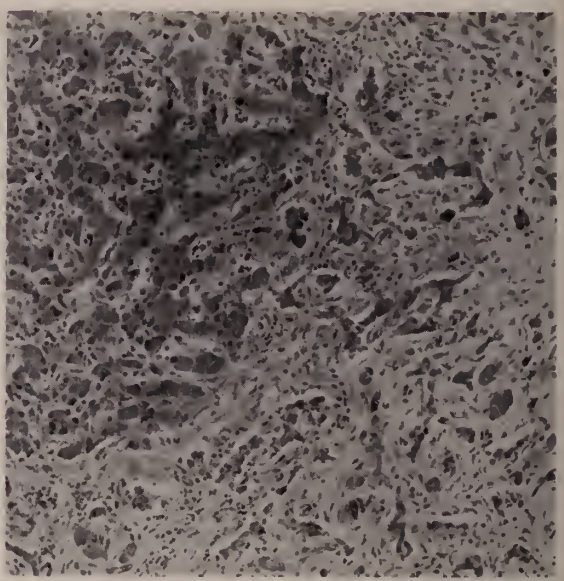


Fig. 5. — Carcinoma of the liver, primary.

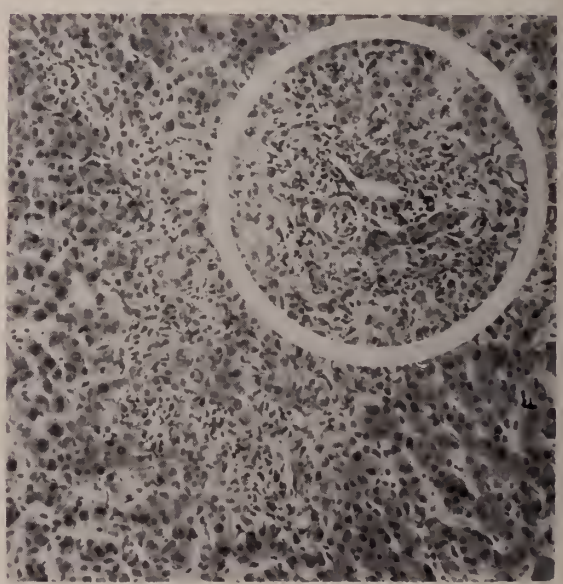


Fig. 6. — Pericholangitis secondary to extrahepatic obstruction.

The abdominal flat plate, upper gastrointestinal series, esophagram, and liver scan, all give helpful clues in locating the source of difficulty (figs. 8-12). The secretin test with study of exfoliative cytology may also prove helpful in a search for pancreatic neoplasms.

V. Surgical Approach To The Diagnosis of Jaundice

Dr. Gilbert.—In that anyone who can read a medical or surgical textbook can accurately enumerate the multiple causes of jaundice, I will not attempt to outline these today. In lieu of this approach, I will try to present my thoughts when I am confronted with a jaundiced patient.

Initially, I must emphasize that jaundice, in itself, is not a surgical emergency. Multiple causes of nonsurgical jaundice have been detailed to you today. The time invested in establishing the accurate diagnosis is certainly time well spent; for in truth, to operate on a jaundiced patient who has some condition which cannot be corrected surgically is to add a great burden to his condition and reduce the chances for survival. First,



Fig. 8. — Flat plate of abdomen demonstrating multiple calculi in the gallbladder in a patient with obstructive jaundice. (See fig. 9)



Fig. 7. — Preoperative transhepatic cholangiogram demonstrating marked dilatation of complete intrahepatic and extra-hepatic ductal system. Carcinoma of the pancreas found at operation.



Fig. 9. — Postbulbar duodenal compression by large dilated common bile duct. Obstructing common duct stone found at operation.



Fig. 10. — Classic "inverted 3 sign" of Frostberg in a patient with carcinoma of the pancreas. Increase in space between gastric fundus and left diaphragm suggested a gastric mass or splenic enlargement but none found at operation.



Fig. 11. — Prominent diffuse esophageal varices in patient with postnecrotic cirrhosis simulating extrahepatic obstruction.

I attempt to classify the jaundiced patient by age group or stage of life. Basically, one thinks of the jaundiced infant in terms of congenital malformation of the biliary ductal system with atresia or cyst formation of part or all of the extrahepatic ductal elements. The syndrome of inspissated bile plugging the biliary tract is for the most part only responsive to operative treatment. Occasionally, the very young may have cholelithiasis or choledocholithiasis. To clarify the issue one must exclude the nonsurgical causes of jaundice in the newborn period, a few being sepsis, blood incompatibility and physiological jaundice of the newborn. The middle-aged jaundiced patient usually has some inflammatory or degenerative process causing his problem; cholecystitis, cholelithiasis, choledocholithiasis, pancreatitis and cirrhosis are a few such disorders.

The older-aged patient may have either the inflammatory or degenerative lesions or a neoplastic lesion. Carcinoma of the liver, biliary tract, pancreas or ampulla of Vater is more frequent in this group.

In the two latter groups, one is primarily concerned with excluding intrahepatic causes of jaundice, such as drugs, hepatitis and cirrhosis, before embarking on surgical treatment.

A thorough history and physical examination alone will frequently allow the examiner to make the correct diagnosis. Even though the exact diagnosis may not be made, an added group will present enough collateral evidence to categorize them as presenting surgical problems.

(Continued on page 339)

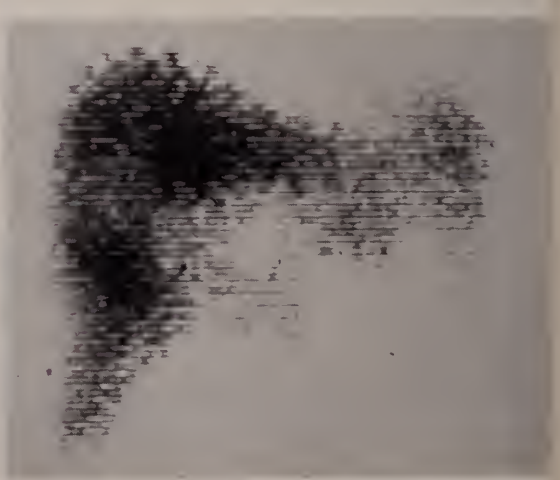


Fig. 12. — Liver scan with Rose-Bengal-I^{131} in patient with highly undifferentiated metastatic adenocarcinoma. Several large filling defects seen in right and left lobes—splenic uptake noted as well.

Problems of a Large Medical Society

WILLIAM J. DEAN, M.D.*

The problems of any medical society, large or small, revolve around the complex processes of providing a rapidly developing scientific professional service to a community undergoing rapid social, political and economic changes; all this to be accomplished within a framework of an exacting body of medical ethics.

A large medical society may be defined as one that has grown from a handful of mutually acquainted charter members imbued with professional and community high purpose to a loosely knit assembly where 20 to 25% of the membership constitutes a large meeting and where society business is conducted by a board that may be elected by as little as 11 to 13% of the voting membership.

This fact alone gives rise to one of the major problems of the large medical society. To quote James E. Bryan, Executive Secretary of the American Medical Writers Association: "Medicine's critics, both inside and outside the profession, often accuse the county society of being a tight little bureaucracy of medical politicians who run the show for their own glory. One hears of the clique that runs things presumably with little regard and less heed for the wishes of the majority."

Mr. Bryan pointed out how easy it is to become a member of the "clique." It may also be added that members of the clique probably wonder when the glory descends.

Should one consider nothing more than these two opening sentences, a profusion of medical society problems becomes evident. Four main problem areas require consideration:

1. Interpersonal relationships within the medical society.
2. Community responsibilities and public relations.
3. Professional education.
4. Management, administration and state and national medical association relationships.

Membership Problems

In any medical society, large or small, the criteria for membership tend to be a bit fuzzy. This confusion is due in part to views within the society as to the ultimate society purpose—primarily one of mutual or intersociety relationships, or one of primary community responsibility. The other confusing factor hinges on variable legal opinions that medical society membership is a physician's property right or the other extreme that membership is not a right but a privilege subject to the blackballs of those that are in. Hospitals requiring medical society membership as a prerequisite to staff appointments tend to support the "property right" opinion. The larger the society the larger loom the criteria for membership selection and classification.

These problems as to who may or should be members lead directly into classes of membership, probationary periods, the society's responsibility for orientation of new members and requirements for attendance at meetings. Medical society attendance is frequently made the subject of a whole symposium, and if but one problem of the large medical society were to be discussed, attendance would probably be the one.

Perhaps we should take some attendance lessons from the Catholic Church, Rotary Interna-

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tional or Kiwanis, as hospital staffs apparently have. Combinations of hospital staff and county medical society meetings are said to boost attendance, but this arrangement presents new problems of time, space, loyalty and coordination.

Regardless of size, for what and to what extent should a medical society discipline its members? In a large society this is a major and controversial problem, a problem complicated by a varying sense of values, varying ideas of right and wrong and varying degrees of understanding, adherence and devotion to the Hippocratic Oath, accumulated medical ethics and avowed medical society purposes. One must also add varying levels of professional competence. What should a society do knowing that one of its members attempts therapeutic or operative procedures beyond his ken, or is a therapeutic nihilist, or worse yet one who habitually capitalizes on elective surgery or multiple shots for every complaint under the sun. In such cases who or what committees become the judge? How far can a medical society go in judging the quality of a member's medical practice when the state finds him fully qualified to practice medicine and surgery and grants him a license which so states? Fortunately, hospital staffs have some authority here as relates to work in the hospital.

Should a medical society have a credentials committee? This question is pertinent when we consider that as a society we in effect endorse our members to the community as competent physicians and surgeons and frequently go so far as to publish rosters categorizing the membership into specialty groups. The office staff, compiling the roster, takes the doctor's word for it when he says, "I'm an internist," "obstetrician," or "general surgeon." As a society we endorse these "specialists" without due consideration of their professional background. The easiest way in the world to specialize is by way of the medical society classified roster or the yellow pages when specialty classifications are listed in the telephone book.

Community Responsibility

The widest differences of opinion relative to problems of a medical society will occur in the area of community responsibility and public relations. At the present time planning for health facilities and services is being presented to medical societies as one of their major community responsibilities; yet when planning programs are reviewed we discover that planning is being accomplished by every civic, political and voluntary group in the community that has any relationship whatever to health or medical activities. Adequate doctor of medicine representation on these groups is the exception. From this very fact it then becomes evident that perhaps a great deal of responsibility does rest on the shoulders of the medical society and that a planning group within the society should take initial action, either independently, or by insinuating themselves into the membership of planning groups already in operation or already financed.

One does not have to be very familiar with current literature to realize that now as never before advantageous or equitable relationships between medical and legal societies are desirable. Each profession has a degree of responsibility to the other as well as to the general public and each should serve to assist the other in protecting the rights of the general public as well as protecting the members of the medical society or the bar association from unfair attacks or legal suits. The composition and method of operation of the medicolegal committees, as well as a code of ethics that should be developed between the medical and legal professions, deserve most careful consideration and should be made a part of the program of every medical society, large or small.

Where does the medical society stand in regard to public health or what should its relationship be with the Health Department or the local Board of Health? There is an increasing stimulus from the federal government for the Public Health Service and individual state and county health departments to take an expanding interest in such activities as disease detection programs. Of particular interest are the nationally sponsored programs for the detection of diabetes, tuberculosis, glaucoma, malnutrition, defective vision and defective hearing. One cannot quarrel with the virtue of these programs and it behooves the medical society to take an active interest and an active part in these programs as well as in other features of preventive medicine including immunizations, sanitation and environmental health.

School health comes in for considerable attention in every medical society. This covers routine physical examinations prior to entering

school and periodically thereafter, an organized school health program and qualifying athletic examinations. This problem increases with the size of a medical society inasmuch as smaller communities are able to enlist greater interest from physicians than is possible in the larger cities. School health programs within the schools themselves to be followed throughout the year are increasingly important. The general public has an increasing knowledge of health matters and demands more attention in this field. In addition, the federal government has started antipoverty programs, a main feature of which is disease detection, physical examinations and follow through health programs of corrective medical care.

In addition to the programs just mentioned, other community health programs require attention from members of the medical society. There is an increasing emphasis on organized approach to community mental health. The medical profession and the courts have ruled that alcoholism is a disease requiring concerted effort on the part of both law enforcement and medical science to assist people afflicted with this disease. All medical societies are urged to sponsor programs designed to study the problems of aging and those of retarded or crippled children. Frequently these latter programs, such as mental health, alcoholism, aging, and retarded and crippled children, are handled by members of the medical society, but they are not acting through the medical society. It would seem much better if volunteers for this community activity could be assured that they had the medical society back of them and were in a position to look to the medical society for support and assistance.

Rumors are about that there is a growing disaffection between the general public and the medical profession. This should be doubted, but wherever it is so, it probably is the fault of the profession. It is too easy to neglect public relations and the education of the public concerning the physician's side of medical practice. Medical societies should make every effort to maintain working relationships with the press and other news media—even though it may appear on occasion to be a losing battle. It is easier to fight City Hall than the press and whenever the effort is made to reach an understanding, it is frequently found that the press and the medical society are on the same side.

Successful approaches to the public can be made through a carefully selected and freely functioning speakers bureau, by sponsoring health forums, fairs and exhibits and by providing an acceptable medical information and counseling service. This public relations approach must be supported by a realistic grievance committee to deal with individual problems. Most grievances will center about a misunderstanding about fees and it is significant that most of these are due to physician fault.

No large medical society can field a membership entirely free of dirty linen. This sad fact makes it imperative that disciplining of errant members be carefully followed even to bitter ends or public confidence may suffer and medical society relations with other health professions must be guarded.

This problem brings up the medical society position concerning exposure of quackery and cultism. If one purpose of the society is to monitor and provide a competent medical service for a community, it should be prepared to face quackery squarely and fearlessly expose it. Of course, unless the medical society keeps its own skirts clean, no pot should call the kettle black.

Professional Education

Continuing medical education is a requirement in medical practice as well as a virtue. It is, however, most touchy to question the professional competence of a member or to suggest any special effort on his part to broaden his medical education and training. This requirement must be met some way and it has been successfully approached by promoting medical center identification and in some cases by an interchange of residents and practitioners. The very least the society should do is to sponsor scientific programs, support local forums, lecture series and hospital clinicopathologic conferences, encourage participation in regional programs for specialty groups and general practitioners, and let it be positively known that continuing medical education is for every member of the society.

Management

The larger a medical society becomes the more complicated and more expensive becomes its management. The society must determine just how much community and professional activity it should engage in and set up a system of management and manning to accomplish this purpose. Such an organization must include a strong central office, realistic fiscal management, and an officer, executive committee, board of governors and committee structure all devoted to the basic society mission. To repeat, special projects include such undertakings as health education of the general public, the organization and operation of a speakers bureau, the cooperation with other news media for the presentation of health forums, the development and supervision of health fairs and exhibits, the maintenance of press relations including all news media as well as the newspapers, the provision of an information service within the office of the medical society, and a readiness and willingness to provide medical and paramedical career counseling for the schools.

In addition to public relations activities already mentioned, what should a society do relative to political activity? Perhaps this question can best be answered by a quotation from Dr. G. C. Andersen's President's Page of the January 6 issue of the Los Angeles County Medical Bulletin:

"No longer can the individual physician indulge in the sanctuary of his personal practice unaware of the forces about him, who would enslave him and his profession. Each one of us must enlarge his horizon to include the whole area of the practice of medicine, realizing that individually, we must maintain the highest quality of medical care possible, and collectively, resist any force from without which may tend to lower that standard of quality."

▶ Dr. Dean, 1515 Fourth Street North, St. Petersburg 33701



President's Page



A DRUG INFORMATIONAL BULLETIN

Chemical identification of the "essential elements" (vitamins) in nutrition and the humoral regulators of physiology (hormones) initiated discoveries which have advanced and expanded the chemical agents (drugs) available to the physician in the treatment of disease and preservation of health. Discovery and development of the antibiotic agents rival in importance any medical discovery in history and have revolutionized medical care.

The pharmaceutical industry has produced vast resources for the research and development of new chemical therapeutic agents. The number and variety of potent drugs and physiological agents available today enhance the physician's effectiveness, but often confound him. "That which is capable of doing great good may also do great harm," is an admonition especially applicable to drugs.

In 1961, The Florida State Department of Welfare was authorized to pay the cost of drugs prescribed by a physician for recipients of state welfare subsistence payments, although the medical advisory committee disapproved the welfare drug program as untimely in the logical development of tax-supported medical care for those in financial need. The cost per eligible recipient of this drug program has been among the highest in the nation.

In 1965, the Governor appointed a committee to study the welfare drug program and make recommendations for more efficient and economical operation. The medical members of this committee are the State Health Officer, Provost of the University of Florida College of Medicine and President of the Florida Medical Association. This committee has made several recommendations approved by the state cabinet to be effective July 1, 1966.

A drug informational bulletin will be published by the U F College of Pharmacy in cooperation with the Florida Medical Association and Florida State Pharmaceutical Association. Drugs will be listed by proprietary names under generic classification and numbered in accordance with the established American Hospital Formulary Classification system. Tabulated adjacent to the name will be information on strength of preparations, packaging and cost. A simplified pricing schedule will be adopted consisting of a percentage supplement to the wholesale price and a professional fee for the pharmacist.

The State Department of Public Welfare will assume responsibility for the processing and payment of all prescriptions utilizing, to the extent possible, fully automated procedures. Readily available information concerning the collective and individual utilization of drugs and prescribing practices will be useful by-products of the automatic data processing.

The Drug Informational Bulletin will be published in loose leaf form and regularly brought up to date. As many as possible of the regularly prescribed medicinal agents will be included and numbered, but physicians will not be limited to the drugs listed and coding of prescriptions will be the responsibility of the state department.

Such a Drug Informational Bulletin should be of value to the prescribing physician, for it will provide a listing of similar drugs, with abbreviated dosage forms, packaging, and cost information, to facilitate comparison.

In order to stay within budgetary limitations, the Welfare Department now limits the drug allowance for each recipient to $20 a month and each prescription to a 30 day supply. It seems the 30 day supply limitation per prescription will be removed soon.

Real economy in drug costs can be better achieved by physicians' voluntary restraint in the use of costly medicinal agents for self-limiting disease and when they are of questionable value rather than by indiscriminate governmental restrictive regulations.

H. Phillip Hampton



The Pathologist, the Radiologist And the Hospital

Editor's Note: Editorial comments concerning the Pathologist-Radiologist relationship to the hospital under the provisions of PL 89-97 are presented. Such a statement was solicited from the Florida Hospital Association and after consideration by its executive board, we have been advised that this is a problem of the individual specialist and the individual hospital administrator; so the state association can make no policy statement. Your comment on these thoughts is solicited.

T.M.

Privileges - Rights - Responsibilities

The tumbled, kaleidoscopic world of change that characterizes today's scientific explosion has conditioned us into somewhat sophisticated, blasé observers inclined to be unimpressed by any but the most dramatic discoveries. Our scientific eye is unclouded, generally, by emotion, prejudice, habit, or personal interest. We have a certain pride in our ability to deal with objective, factual data—to act logically and progressively, in our search for truth. But our philosophical eye gives us more trouble. It remains persistently myopic, and as it gazes on the slow evolutionary process of social convention and development, it often forms retinal images less accurate—less sharp—less precise—than those transmitted by its scientific companion—images which seem to reach our brain with the emotional and often erroneous result that, somehow, Society—Man himself—is static, and that here the evolutionary process no longer proceeds. Logic and thoughtful judgment refute this concept. Indeed, none but the strictest fundamentalist would maintain that our particular twig of the vertebrate branch of the tree of life is not still in the process of evolution, and that the social customs, habits and development of our species do not continue; but this slow unfolding is in such contrast to the swift-moving, dynamic explosions of the space age, especially in the medical world, that, by comparison, its progress seems absent. This only *seems* to be so.

A thoughtful look at our present and our past brings us to the realization that significant changes—for better or for worse—are taking place in Man and his Society, with emphasis on development of the aggregate, rather than upon individual reaction and effort. Medicine—like Man—must adapt to these changes and must play its part in their development.

One of the hereditary malformations of medical practice in this century has been the fractionization and the restricted hospital-cultured growth of a few specialized branches of our profession—notably Radiology and Pathology. These two large and important segments of medical practice have, since infancy, been adopted by, and nurtured in, the hospital environment, until their very existence as professions, rather than technologies, has been in danger. Apathy has fostered the continuation of this abnormal segregation.

Several years ago, in Florida, forward-looking individuals in both disciplines, as well as leaders of our Medical Association, initiated efforts to

restore the full dignity of the Physician—his rights —privileges—and his traditional stature—to both of these groups. In this endeavor, Florida assumed a leading role nationally, by establishing a state policy favoring open staff and independent billing for Radiologists. Similar state actions have taken place throughout the country. Paradoxically, the distasteful Medicare Law, to which most of us so strenuously objected, added the telling and effective blow. The result is a national consensus that Radiologists, Pathologists, Anesthesiologists, Physiatrists, and all others who aspire to the name of Physician, shall act as agents independent of the hospital and as Doctors in their own right—selling their own services directly to their patients.

This is a significant advance in the ethic of Medicine. This is a part of our current evolution. Adaptation to this laudable principle will not be easy—particularly if we view it only through our myopic eye. The privilege of the wider rights of the Physician carries with it the responsibilities that every Doctor must bear. These responsibilities—and those of the hospital, now about to lose its foster sons, demand of both—individual and institution alike—a new dedication to the raison d'être for each: the patient. Our adaptation must not inconvenience him unduly and certainly must not result in less effective care. Neither should it result in increased patient cost beyond actual expense plus the fair profit to which the institution and the Physician are entitled.

Various contractual percentages have been in effect between hospitals and Physicians. Unfortunately, these have often depended more upon fiscal maneuvering—volume of assured patient-load, et cetera—than upon the sounder cost analysis and fair fee-for-service. It would seem logical that, after a careful and analytical study has determined what the technical cost of x-ray or laboratory service is in any particular area, a just profit should be added to this amount in determining the final technical charge for either hospital or physician-owner; and that, secondly, a fair professional fee for interpretation of films or tests should be established, regardless of the environment in which it is carried out. This course will demand some readjustment of fees, and undoubtedly even of overall hospital charges, so that if, unwittingly, a large x-ray department has supplied a disproportionate portion of hospital income used to defray expenses of those patients who have few, if any, x-rays, readjustments will need to be made involving the room rates or other common denominators. This provision would seem only honest and just. Certainly the total expense to the patient, for x-ray or laboratory work, should not be increased, unless such increase can be justified by a careful analysis of present technical costs and living indices. If mistakes in accounting in these two areas have been allowed to persist in the past, now is the time to correct them, so that, in the future, we may honestly substantiate our fees, both for care and Physician service. Let us do all this with the patient's interest as our paramount directive.

These are responsibilities of the rights and the privileges which we seek.

Jere W. Annis, M.D.
Lakeland

The Radiologist and His Fee For Service

Government regulations and requirements imposed on radiologists by Public Law 89-97 are, if nothing else, serving to return the long-lost sheep into the medical fold. After over half a century in which their services in hospitals were purveyed to the patients, most often at a profit, such a procedure will no longer be possible under the new Medicare law.

In order to avoid the confusion of dual methods of billing for Medicare and non-Medicare patients, the radiologists throughout the nation have proposed that on or about April 1, 1966, all hospital radiological fees be divided into professional and technical components with statements for the former submitted to the patient by the radiologist and for the latter by the hospital. All parties involved would then have three months to institute adequate methods of billing so that with the onset of Medicare on July 1, 1966, a smoothly functioning operation could be anticipated.

It is the intent of the radiologists that under the new separate billing arrangements the total of the combined fees should not exceed the previous fee for any particular service.

As a matter of fact, it is hoped that hospitals will lower their income from the technical portion of the fee by not seeking to make an exorbitant profit on x-ray in order to lower the charges for rooms. The hospital can calculate its charge for the technical component of x-ray services in the same way it establishes fees for patients using the operating rooms, obstetrical delivery rooms and other special services. Since the government will pay reasonable charges for rooms, there will be no need to set these charges at levels which result in an operating loss. A similar philosophy should obtain for those patients who are not under Medicare. The hospital will no longer have to adopt the mercantile methods of having loss leaders in room charges and overcharging on x-ray services.

Since the radiologist is now placing himself in the position of all other members of the hospital staff, he will no longer have a binding contract for a fixed period of time. This change implies an open staff in which the radiologist applies for privileges as do other members of the medical community. The chief of radiology serves in the same manner as do the chiefs of other services and assumes the administrative responsibilities of the department. No longer will one be able to level the charge of monopoly at a radiologist and no longer will an incompetent be protected by a legal instrument. His tenure will be dependent upon the quality of service rendered, which is as it should be.

The proposed change in billing has received the support of the American Medical Association as well as that of its individual members who are not radiologists. It is also receiving widespread acceptance by hospital administrators and hospital governing boards. Many problems will arise in connection with this transition, but with the considerate help and sympathetic understanding of everyone involved, it is believed that this will ultimately represent a beneficial change for patients, hospitals and all physicians.

David Kirsh, M.D.
Miami

Changing Traditions

As the result of federal legislation, we are embarking on a new concept in establishing fees for the services of pathologists, radiologists, and other specialists who have close relationships with their hospital. The pathologists and radiologists have decided to divide their fees into professional services and technical services. This is a new concept in establishing professional fees.

It is the responsibility of the medical profession to establish realistic fees, particularly regarding the technical component. It has been implied in the past that hospitals have been making large profits on laboratory and x-ray work in order to make up the deficit as a result of not charging the realistic costs of hospital beds to the patients and third parties. The larger hospitals and the federal government, with modern cost accounting, will readily discover in a short period of time whether or not the technical component is a realistic value based on technical cost, cost of materials and equipment needed.

These same principles will apply to all services in which professional supervision or interpretation is required.

The division of professional fees into a professional component and technical component has far reaching implications. If the technical component is a highly profitable figure, rather than a figure related to realistic cost, I predict that the federal government and other third parties will see that these fees are lowered to realistic fees. If these procedures are lowered to realistic fees, hospitals will immediately be faced with the problem of raising the cost of hospital beds to a realistic figure which is approximately one and one-half times the cost of a semiprivate bed at the present time.

In 1964 the national average cost was $41.58 a day per bed, including ancillary services.

Another factor of this very complicated problem is the acceptance by the public of paying for the professional component of the services of pathologists, radiologists, and other specialists by separate statements.

If this whole concept of professional and technical components of professional fees is widely accepted for pathologists and radiologists, it appears that the concept may spread to all physicians and we will be billing an office visit, a special or surgical procedure, and so on, with a technical component in addition.

The success or failure of this new concept in billing will affect every member of the medical profession.

Charles K. Donegan, M.D.
St. Petersburg

Pathology at the Crossroads

The Executive Council of the Florida Society of Pathologists met in special session in Orlando on Jan. 30, 1966, because of grave concern over the current status and future prospects for the practice of pathology, particularly as this medical specialty may be affected by Medicare. During this meeting the Executive Council directed me as president to express to the members of the Florida Medical Association the deep convictions which were developed at that meeting. We believe that this matter is of equal concern to all physicians because, if one specialty group of physicians is allowed to become controlled completely by laymen and compensated by Social Security as a hospital service, it sets the stage for the gradual entrapment of each specialty and each physician in the ever tightening tentacles of lay groups, bureaucrats and organizations who would control the entire practice of medicine. The FSP Executive Council believes that it is safe to say that as pathology goes, so inevitably will go the other branches of the practice of medicine. These self-appointed planners would divide and conquer and we must counter by joining together and preserving the freedom of all medicine. This editorial has been considered carefully by the Executive Council and has been given its unqualified support.

During this special meeting of the Executive Council, the various phases of Public Law 89-97 as they affect the practice of pathology were considered in depth. As the multiple problems unfolded, the distinct impression became evident in the minds of the Executive Council that hospital pathologists are in serious jeopardy of being separated from the rest of the medical profession and becoming merely hospital employees with virtually complete dependency on the policies and desires of hospital administrators. At that same meeting, the members of the Executive Council also expressed much concern that pathologists in private office practice are going to be faced with Medicare regulations which may lead to little or no control over the types and quality of work being done in independent medical laboratories which are given approval for professional services to Medicare patients. If such regulations are developed, the Executive Council believes that laboratories of the type given approval for Medicare patient services will inevitably gain unlimited freedom to perform an ever increasing amount of work on all patients.

It was pointed out that the control of independent laboratories may be under laymen who have minimal qualifications—individuals who are completely free of the moral, ethical and legal restraints which are placed on the medical profession. These laboratories, which are substandard by the policies of organized medicine, will possibly be given an equal status with the laboratories of properly qualified and ethical pathologists. One point which was stressed at the meeting was the fact that payment to independent laboratories may be made by the referring hospital or physician, a philosophy alien to the established policy of the American Medical Association, its component state societies and the College of American Pathologists. This plan of payment has the real hazard of leading to fee splitting and other unethical, if not illegal, patterns of remuneration.

The Executive Council of the Florida Society of Pathologists, with its constitutionally defined authority to speak for the entire FSP membership, believes that now is the hour of decision if pathology is to be saved from separation from the rest of medicine and complete socialization. The FSP feels that any hesitancy on the part of pathologists to meet these multiple issues squarely and with absolute candor will lead to the very loss of the practice of pathology as a medical specialty. We believe that the facts in the matter suggest the strong possibilty that the American Hospital Association, in cooperation with persons in high position in the Department of Health, Education, and Welfare, is in the process of distorting the letter and the spirit of the law for the purpose of having the so-called Douglas Amendment enacted without congressional approval. The Douglas Amendment, which was ultimately defeated in the Congress, would have made the professional services of the hospital-based specialists (pathologists, radiologists, anesthesiologists, physiatrists) paid under Part A of Title XVIII of Public Law 89-97 (Medicare). Part A is the compulsory Social Security program designed to pay hospital bills. The Congress decided that no physician (except interns and residents) could be paid for his professional services under Part A but must be paid through Part B, an optional program designed primarily to pay doctors' bills. We believe that it is fair to say that those individuals who would attempt, by distortion of the rules and regulations, to change the intent of the Congress in the Medicare Law, are our mortal enemies and will stop at nothing to gain their wishes.

The FSP believes that physicians in general and pathologists in particular have been lulled into a false sense of security by the published statements of representatives of the AHA and HEW. We believe that organized medicine has developed the faulty impression that the rules and regulations for Medicare are going to be developed in accordance with the expressed principles of the Congress. Organized medicine seems to have been guilty of wishful thinking in the belief that the regulations will keep all actively practicing physicians (with a few specific exceptions) from payment for professional services through Social Security. The recently published principles of the Health Insurance Benefits Advisory Council seem clearly to us to subvert the wishes of the Congress for the purposes of giving HEW and the AHA the mechanism for placing hospital-based specialists in Part A of Title XVIII. By this technique the AHA will regain its plan, lost in the Congress, which would make these hospital-based specialists lose their identity as physicians and become merely another hospital service.

This plan to enact the Douglas Amendment without the approval of the Congress is summarized very effectively by the statement of the College of American Pathologists as prepared with the assistance of E. Barrett Prettyman, Jr., Esq., an attorney of Washington, D. C., recently retained by the CAP. The pertinent part of Mr. Prettyman's analysis is quoted as follows:

> In brief, HEW's Principle Three and the discussion immediately following it provide that the only physician's service reimbursable under Part B is an identifiable service requiring performance by a physician in person and on behalf of a specific, individual patient. Thus, as applicable to the College's members, Principle Three excludes from payment under Part B the pathologist's 'professional component' that part of his time spent in setting standards, establishing controls and otherwise supervising the clinical laboratory for which he is individually and directly responsible, even though HEW admits that this service requires the pathologist's 'professional expertise'.
>
> In practical effect, Principle Three also prevents direct billing by the hospital-based pathologist except in those relatively few instances where he has personally reviewed the specimen or file of an individual patient. In all other cases, since Part A funds can be paid only to the hospital, and since Part B funds are not available for what Principle Three defines as Part A services, the effect of Principle Three will be to prevent direct billing of patients by the hospital-based pathologist.
>
> "The Act and its legislative history demonstrate, on the other hand, that Congress intended for the supervisory functions of hospital-based specialists to be reimbursed out of Part B funds and that Congress did not intend to prevent such specialists from billing the patient directly.

The FSP would like to know if those congressional leaders who worked so long and arduously to keep physicians free from the control of Social Security are aware that their efforts which were successful in the Congress are, in essence, being ridiculed by the manner in which the rules and regulations for the Medicare Law are being established. The FSP wonders if these capable and effective congressional leaders will allow such a mockery to take place.

The FSP takes the unequivocal position that pathologists must dedicate themselves to the task of salvaging as many of these losses as we can. There is no time to spare. It is imperative that we plan a clearcut course of action and do everything

to see that it is followed by all pathologists with support from all of our fellow physicans. The basic precepts of this course of action should lead to the freeing of the hospital-based pathologist from the control of hospital administrators and should also lead to the independent laboratory pathologist being free from having to fight substandard commercialized lay laboratories which almost always have monetary profit as their sole motive for existence. The following program is suggested.

1. Work closely with organized medicine. The FSP believes that pathologists must carry on their program by speaking through organized medicine. We recognize the fact that we have limited effectiveness when we speak solely as pathologists, but when we have the support of organized medicine our voice is heard clearly. As the principal spokesman for organized medicine, the American Medical Association has been on record time and time again as upholding the principle that pathology in all its phases, both anatomic and clinical, is the practice of medicine. Similar philosophies have been expressed in many state medical associations. We believe that, if the AMA and its component state societies, in accordance with their well established policy decisions, point out to the appropriate congressional leaders the subversion of the law which is being made by the proposed HEW regulations, modifications may still be made. We also believe that organized medicine may be able to be very effective in helping to shape proper regulations for adequate control of independent laboratories.
2. Noncooperation. If HEW persists in this plan which appears to be a clear distortion of the Medicare Law, the FSP believes that serious consideration should be given to the development of policies which would lead pathologists away from cooperation with, and support of, the Medicare Law. The FSP believes that pathologists may reasonably be expected to develop the concept that they have no obligation to cooperate in this program which seems clearly an attempt to enact the Douglas Amendment without the benefit of congressional approval.
3. Legal action against HEW and AHA. The FSP also believes that, if no modifications are made in these proposed Medicare regulations, the AMA and the College of American Pathologists should institute prompt and vigorous legal action against HEW to force modifications in the proposed regulations. Such action is in accordance with the expressed interpretation of the recently retained CAP Washington legal counsel who stated that there is reason to believe that the proposed rules and regulations are contrary to the law. Proceedings of this type must be instituted without delay if there is to be any possibility of modifying these regulations. The FSP believes that it is probable that HEW and the AHA are working together to alter the law to fit their own desires. Because of this state of affairs the FSP believes that the AMA and the CAP should seriously consider the possibility of instituting legal action against the AHA if the regulations are not properly modified.
4. Question advisability of lease arrangement. The FSP questions seriously the CAP policy of advocating the lease arrangement for the hospital-based pathologist. It seems clear that hospital administrators and boards of directors can readily be convinced that lease arrangements may lead to loss of the tax-free status which hospitals currently enjoy.
5. Mutual working agreement. As an alternative to the lease arrangement, the FSP has become quite interested in the so-called mutual working agreement plan for handling hospital pathology service. This plan, which has been developed primarily through the efforts of the state pathology societies in Nebraska and Idaho, establishes an arrangement whereby the pathologist has complete control of the laboratory and there is elimination of any loss of tax-free status by the hospital. This has been given a careful legal study by attorneys knowledgeable in such matters and there appears to be no reason to doubt that

such an agreement can be established on a sound legal basis. In the mutual working agreement, the pathologist employs and maintains the privilege of hiring and firing all personnel in the pathology department. The pathologist is in charge of the total billing and collecting services for pathology and pays all salaries of personnel. The pathologist pays for all supplies and equipment. An absolutely essential part of such an agreement is that the pathology department must be operated to the satisfaction of the hospital medical staff. The pathologist has the responsibility for seeing that the pathology department develops in accordance with the needs of the medical staff and that there is a continuing program of self improvement in the department. This type of an arrangement eliminates the hospital administrator and the hospital lay boards from the relationship with the department of pathology which, in effect, has had these nonphysicians exerting absolute control over this type of medical practice in many instances.

6. Direct billing of patients. The FSP believes that it is essential for each pathologist to bill patients directly for his professional services in both anatomic and clinical pathology. The use of the hospital as a billing agent is to be avoided because this type of an arrangement is not thought to be in the best interest of the patient or the pathologist. This principle of direct billing is in accordance with the established policy of the House of Delegates of the FMA which approved the philosophy of direct billing as developed by the Judicial Council of the FMA. The AMA, the CAP, and the FSP have all developed policies which would support the concept of direct billing by all physicians to patients to whom their professional services have been provided.
7. Complete and prompt interchange of information. The FSP believes that the full facts as they develop in Medicare and other similar matters should be promptly disseminated to all physicians. The well established techniques of the American Hospital Association in fully informing and mobilizing its membership must be copied by organized medicine. We must be kept constantly informed of the developing policies, actions and plans of the American Hospital Association, the Department of Health, Education, and Welfare and other organizations which are so involved in the practice of medicine. National, regional and state conferences and workshops on Medicare and related problems should become a part of a continuing program of all fields of organized medicine.

In short, the Florida Society of Pathologists believes that physicians in general and pathologists in particular can delay no longer in recognizing honestly and openly the true motivations of the enemy in this struggle and the accomplishments which they appear to be achieving. We cannot accept defeat in this battle without an all-out fight to maintain our integrity as physicians. We would once again remind all of our physician colleagues that we in pathology are in urgent need of their fullest support in waging this battle which is not for the preservation of pathology alone but is the focal point of a struggle for the continued freedom of all medicine. Although it may sound somewhat dramatic, we would point out to all physicians that our founding fathers in 1776 recognized the fact that, when they signed the Declaration of Independence, they were risking everything they had, including their lives. We believe that we must have this same sense of dedication if we are to preserve pathology and, by this action, also save the entire practice of medicine from the tyranny of socialism. Although the situation is grave, the danger is real and the hour is late, let it never be said that the pathologists of Florida and of the entire United States together with their fellow physicians did not stand up and be counted at the crucial moment.

Sanford A. Mullen, M.D.
Jacksonville

Medicine and Religion

"God so loved the world that He did not send a committee." Thus has some wit paraphrased St. John's statement that God so loved the world that he sent his only begotten Son to suffer death upon the cross. Easter, with so much emphasis on one man, is a suitable occasion to reconsider the importance of the individual to both medicine and religion.

In early Christian times the priests were the doctors, following the example of Jesus in his healing ministry, and the first hospitals were hostels run by the clergy along the route of pilgrims to the Holy Land. As the centuries passed the two professions became separate, yet closely related, and were held in highest regard by the community. More recently the tremendous scientific advances have had a paradoxical deleterious effect on the regard with which the medical profession is held, and have caused a similar disenchantment with the clergy who are often accused of living in a spiritual dream world far removed from the materialistic world of today.

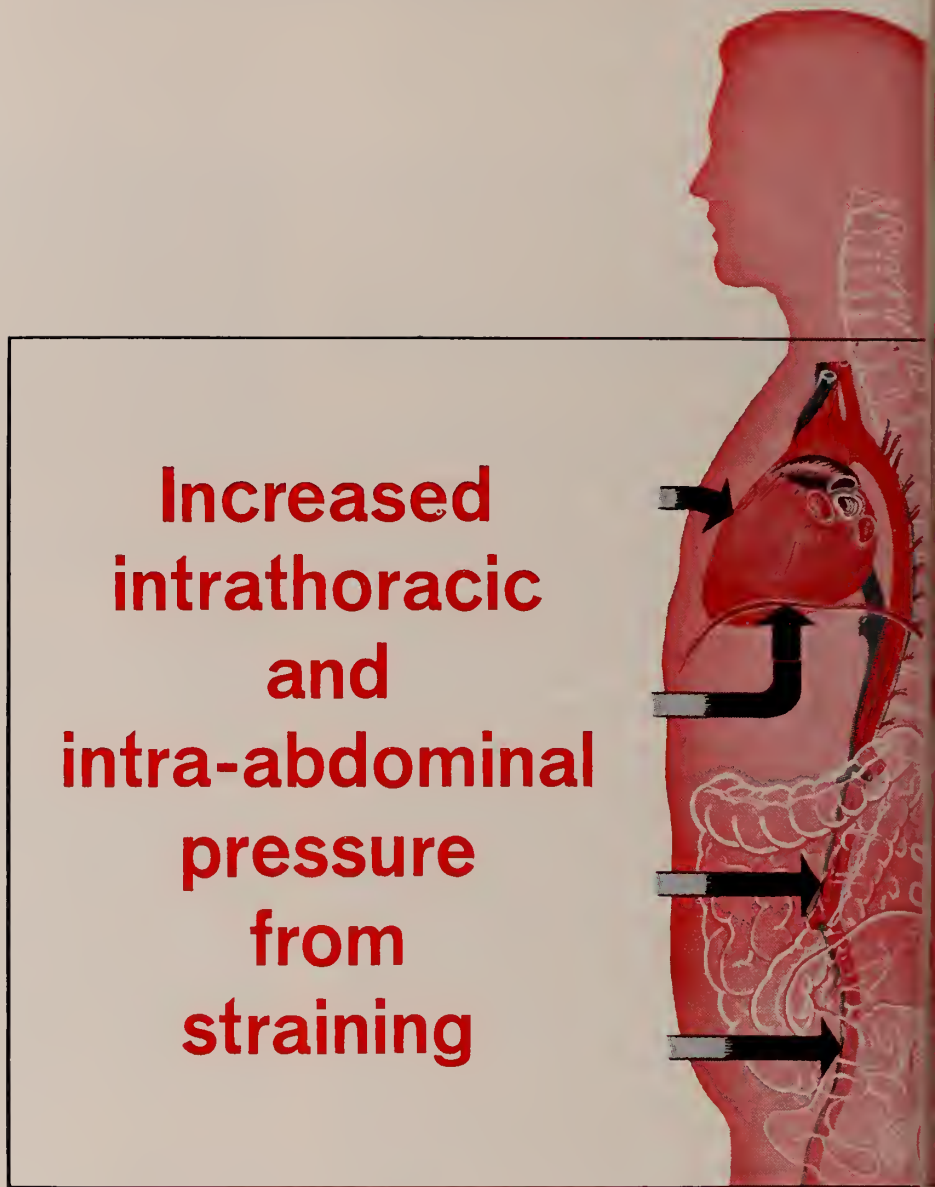
Yet the opinion-testers tell us that the individual doctor is still held in high esteem by his own patients, and presumably the same is true of the individual clergyman. Each of us who practices medicine has at times been flattered, and humbled, by the patient's remark, "Doctor, I feel better the minute you walk in the room." Such faith is not only humbling but is a potent force which each of us uses, often unknowingly, when we treat the sick. Likewise, the faith of the doctor in his methods of treatment is just as important as the faith of the patient in the doctor. This faith has made necessary the "double-blind" method of drug testing, which alters the drug without disturbing the relationship between doctor and patient.

The clergyman likewise deals in faith in his profession, and is aware that man is a creation of flesh and spirit, but that the spirit cannot function except in and through the flesh. When the body is sick, the moral responsibility of man is reduced. The medical missionaries recognize this, for the sick or hungry have no interest in the state of their souls until they have been made comfortable.

Pastoral care in the hospitals is a widening field in which the clergyman pools resources with the physician to work together as a team in mutual confidence and practical helpfulness in healing men's minds and bodies. The doctor's efforts to cure the disease may blind him to the many other needs of the patient which can be noted and perhaps relieved by a perceptive pastor. Sharing such experiences tends to improve the quality of care rendered by both doctor and clergyman outside the hospital, and both might benefit from remembering Dr. Francis Peabody's famous quotation: "The secret in the care of the patient is to care for the patient."

John M. Packard, M.D.
Pensacola

See LETTERS, page 336, for Drs. J. Walter Beck and Frederick E. Farrer's comments on the March editorial "Intestinal Parasitic Infestation," by Dr. E. Charlton Prather.



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NEWS



Dr. Stewart

FMA Member Elected To Board of Chancellors

Dr. John S. Stewart, Fort Myers, councilor of the Florida Radiological Society, was elected to the Board of Chancellors of the American College of Radiology at the annual meeting of the ACR held at the Drake Hotel, Chicago, February 1-5.

Public Health Conference To Be Held at UM

A Public Health Conference on the Use of X-Rays in Medicine and Industry, sponsored by the Florida State Board of Health and the University of Miami, with the cooperation of the U. S. Public Health Service, will be held at the University of Miami Student Union Building April 13-15. The purpose of the conference is to more clearly define the contribution of x-rays to population radiation exposure.

Misleading Advertising Flier Seen As Promotional Scheme

An organization representing itself as the United States Medical Advisory Board is mailing advertising fliers offering physicians a publication entitled "Doctors and the New Social Security Law—Publication #2236-A" at a charge of $3.00 per copy.

In a letter to Florida Congressman Charles E. Bennett, the Social Security Administration stated that the flier appears to be a promotional scheme "deliberately prepared to create the impression in the minds of doctors who receive it that a government publication of some sort is being offered to them at $3.00 a copy."

The SSA further stated that they intend to discuss the matter with the Federal Trade Commission.

H. Doyl Taylor, director of the AMA Department of Investigation, an attorney and former journalist who has devoted considerable time investigating persons pretending to be members of the medical profession or to have its blessing stated to the SSA that he had never heard of the United States Medical Advisory Board. Mr. Taylor said he intended to make an independent investigation to find out more about the firm.

Gastroenterologist Speaks at Pilot Program

Dr. Edwin O. Polish, gastroenterologist from the Hahnemann Medical College and Hospital Department of Medicine, Philadelphia, was the guest speaker at a postgraduate course sponsored by the St. Lucie - Okeechobee - Martin County Medical Society. The program consisted of a series of lectures, rounds and discussions presented in Stuart and Ft. Pierce March 3-5.

Dr. Polish spoke on Diseases of the Esophagus, Differential Diagnosis of Jaundice and The Patient with Diarrhea.

The postgraduate course was a pilot project to establish a continuing education program which the Society hopes will become one of its major activities.

Internists Annual Meet To Hear SSA Consultant

Dr. James Feffer, chairman of the Medical Services Committee of the American Society of Internal Medicine, will speak on "Medicare and Internal Medicine" at the Florida Society of Internal Medicine's annual meeting May 14 being held in conjunction with the FMA annual meeting May 12-15 at the Diplomat Hotel, Hollywood Beach.

Dr. Feffer, a private practitioner in Washington, D.C., is a consultant to the Social Security Administration, and is reported to be in close touch with the internal workings of Washington as far as Medicare is concerned.

Dr. Feffer will also participate in a luncheon panel with Dr. David Reid, Florida Blue Shield actuary, and Dr. Charles Donegan, St. Petersburg, a past president of the ASIM, representing the private practice of internal medicine.

Stroke Symposium To Be Held at UM

The Department of Neurology of the University of Miami is presenting a Symposium on Strokes to be held at the Eden Roc Hotel, Miami Beach, May 16 and 17.

AMA Annual Convention Scheduled for June

Population expansion, a subject much discussed in both medical and lay circles, will be one of six topics presented in general scientific sessions at this year's AMA Annual Convention.

The convention is to be held in Chicago June 26-30. The scientific program will be held at McCormick Place and the House of Delegates will convene at the Palmer House.

The entire scientific program for the 1966 Annual Convention will be published in the May 9 issue of the Journal of the American Medical Association.

Board of Health Appoints Heart Disease Director

Dr. M. E. Groover has been appointed by the State Board of Health as head of the Heart Disease Control Program of the Bureau of Adult Health and Chronic Diseases. Dr. Groover is board certified in Internal Medicine and Cardiology and holds his Masters degree in Public Health from Johns Hopkins University. Prior to accepting the Florida position, Dr. Groover was a member of the faculty of the University of Oklahoma School of Medicine, Oklahoma City.

Florida Heart Association To Hold Seminar

The Florida Heart Association will hold its Ninth Biennial Seminar May 5-7 at the Carillon Hotel, Miami Beach. Some topics of discussion will be: electrical treatment of arrhythmias, coronary care units, assisted circulation and surgery of coronary artery disease.

Miami ACS Chapter Elects New Officers

The Greater Miami Chapter of the American College of Surgeons announces the election of new officers. The new officers are: president, Dr. Edward Cullipher; vice president, Dr. James Merritt; president elect, Dr. Robert L. Swink; secretary-treasurer, Dr. Richard Dever.

Harvard Medical Dean To Speak at UF

Dr. Robert Ebert, dean of the Harvard Medical School, will be guest speaker for the Alpha Omega Alpha Honorary Medical Society Annual Lecture and Banquet April 29 in Gainesville. The talk will be given at 4:00 p.m. in the Medical Sciences Building of the J. Hillis Miller Health Center.



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insufficient base, result in strain of
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muscles** ☐ **to restore mobility.**

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inflammatory, traumatic, and degenerative mus
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motor activity in certain neurologic disturban

Contraindications: Allergic or idiosyncratic r
tions to carisoprodol.

Precautions: 'Soma', like other central nerv
system depressants, should be used with cau
in patients with known propensity for taking
cessive quantities of drugs and in patients
known sensitivity to compounds of similar che
cal structure, e.g., meprobamate.

Side Effects: The only side effect reported with
frequency is sleepiness, usually on higher t
recommended doses. An occasional patient
not tolerate carisoprodol because of an indivi
reaction, such as a sensation of weakness. O
rarely observed reactions have included dizzin
ataxia, tremor, agitation, irritability, headache
crease in eosinophil count, flushing of face,
gastrointestinal symptoms.

One instance each of pancytopenia and le
penia, occurring when carisoprodol was ad
istered with other drugs, has been reported, as
an instance of fixed drug eruption with carisopr
and subsequent cross reaction to meprobam
Rare allergic reactions, usually mild, have inclu
one case each of anaphylactoid reaction with
shock and angioneurotic edema with respira
difficulty, both reversed with appropriate ther
In cases of allergic or hypersensitivity reacti
carisoprodol should be discontinued and appr
ate therapy initiated. Suicidal attempts may
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depression.

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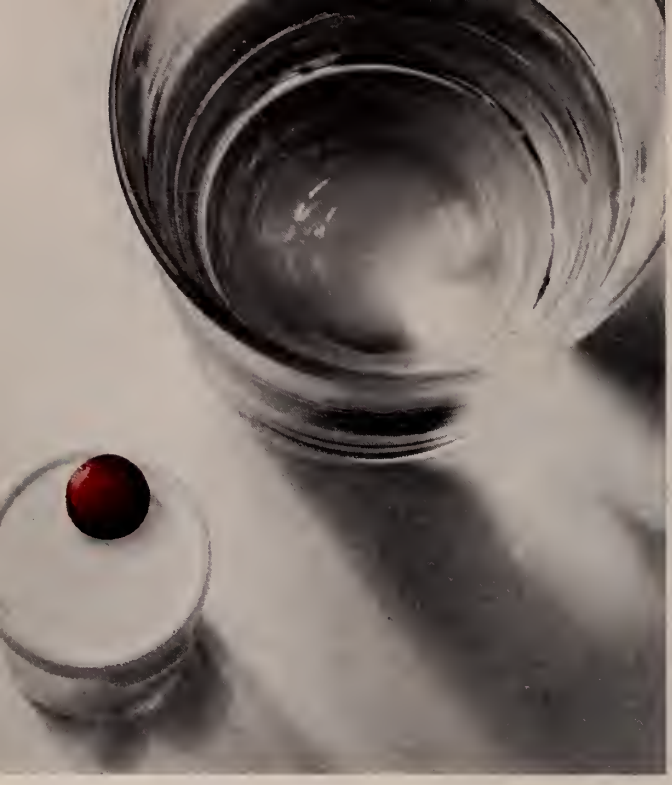
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Warning — In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of discomfort.

Precautions and Side Effects — Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosy crasy occurs, discontinue medication and ins tute appropriate therapy. Anaphylactoid rea tions have been reported.

Contraindication—History of hypersensitivity demethylchlortetracycline.

Average Adult Daily Dosage: 150 mg q.i.d. 300 mg b.i.d. Should be given 1 hour before 2 hours after meals, since absorption impaired by the concomitant administration high calcium content drugs, foods and son dairy products.

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Committee Meetings

Committee on Medical Technologists

The committee met January 8 in the FMA building, Jacksonville. Previous action of the committee on placing the Florida law on medical technology under the supervision and control of the State Board of Medical Examiners was discussed, and it was reported that the SBME has agreed to accept the responsibility, although no official communication from the Board to this effect has been received.

The committee established the following principles as a guide within which the revisions to the law should be made:

1. The Florida law on medical technology be under the supervision and control of the State Board of Medical Examiners.

2. Licensing of laboratories be under the same law as licensing of personnel, and licensing and approval of laboratories be administered by the State Board of Health under the direction of the SBME.

3. Requirements for licensing of both laboratories and personnel conform as nearly as possible to the standards set by the Department of Health, Education, and Welfare.

4. The means for implementation of the law shall be adequately budgeted to provide for proper supervision, but fees shall not be prohibitive.

5. Proper supervision of laboratories under this law shall include renewal of licenses annually and a formal inspection at least every three years.

6. The law on medical technology will not provide for accreditation of schools of medical technology; the State Board of Education shall be encouraged to provide adequate educational facilities for training medical technology personnel, and the SBME shall determine minimum standards of education required for admission to the examination.

The committee began its deliberation on the actual changes and revisions of the Florida law on medical technology, and these remaining portions are to be divided among the committee.

Considerable discussion was held concerning the requirements for qualification as Medical Technology Director under the regulations for Medicare by the Department of HEW.

The meeting concluded with discussion of whether blood banking should be included in the medical technology law. No definite recommendations were established.

Committee on Scientific Work

The committee met January 9 at 1 Davis Boulevard, Tampa. The need for continuing consultation with faculty representatives of the state's two medical schools was discussed, and a motion carried to recommend the addition of ex-officio representatives of the two schools to the committee.

Scientific exhibits were reviewed and accepted for presentation at the 1966 annual meeting. A motion carried to recommend to the Scientific Council and Board of Governors establishment of cash awards for outstanding exhibits.

A general discussion was held concerning the entire scientific portion of the annual meeting to be held Friday, May 13. The combined scientific sessions earlier proposed for Saturday morning were cancelled due to conflict with specialty group meetings. The final scientific program for the annual meeting was agreed upon and adopted.

Committee on Public Health

The committee met January 23 in the FMA building, Jacksonville. A discussion was held of the possible ill effects of insecticides from air insecticide machines installed in establishments where food is prepared and consumed. In view of a Public Health Service study currently in progress, the committee intends to further investigate the use of insecticide machines before making a definite recommendation.

Miss Mildred Kaufman, director of the Division of Nutrition, State Board of Health, discussed the problem of vending machines in the public schools. She reported that there is a trend throughout the country to replace the type "A" school lunch program with vending machines. Miss Kaufman was requested to draft a resolution embodying the committee's thinking urging adoption in all public schools of the type "A" lunch program and discouraging vending machines.

Harvey Burnette, SBH Venereal Disease Control Program director, discussed venereal disease in the state. A motion was carried to reaffirm previous VD recommendations of the committee, to encourage counties already having VD education in the schools to continue urging its adoption in counties where it is not taught, and to recommend that county medical societies initiate VD education programs for their members and for teachers in local schools.

The chairman advised that the Council on Medical Services had expressed concern regarding the extent of raw milk consumption and its effect upon health, and had requested the committee to study the matter and make recommendations. Following careful consideration, a motion was carried recommending the introduction of a bill at the next session of the legislature establishing a statewide pasteurization law outlawing the sale of raw milk.

It was brought to the committee's attention that the State Board of Health/State Dental Society oral cytology study, originally approved by the committee for regional implementation on a pilot basis, had been expanded on a statewide basis upon the recommendation of the program's advisory committee.

The chairman advised that the question of future utilization of state tuberculosis hospital beds had been referred to the FMA for study and recommendations. Because the full import of chest diseases in Cuban immigrants in South Florida is not yet known, and in view of the present vacancy of beds in tuberculosis hospitals, it was strongly recommended that the state TB board, in cooperation with the SBH, study the feasibility of using these vacant beds for other chronic diseases and defer any decision regarding closing a hospital pending results of the study.

A general discussion was held concerning cooperation between health departments and private physicians. It was felt that many of the past problems have diminished and that private physicians are becoming more aware of their community responsibilities.

Dr. E. C. Prather, director of the SBH Division of Epidemiology, discussed changes in the Vaccination Assistance Program under which emphasis has been placed on the eradication of measles, for which there has been a budget allocation increase. A motion was carried to approve the addition of measles vaccine to the SBH immunization program under existing FMA policies.

The final item was a discussion of promoting the statewide voluntary PKU testing program. Hope was expressed that all physicians will actively participate.

SCHEDULE OF ACTIVITIES

FLORIDA MEDICAL ASSOCIATION ANNUAL MEETING

Hotel Diplomat, Hollywood-by-the-Sea, May 11-15, 1966

Wednesday, May 11

All Day	Press Room	Room #116
All Day	Staff Work Room	Room #115
All Day	Woman's Auxiliary Committee Meetings	Mezzanine Rm. 200A
9:00 a.m.	Set Up Exhibits	Convention Hall
1:00 p.m.	Blue Cross Board of Directors, Luncheon	Embassy Room
2:00-4:30 p.m.	General Registration	Convention Hall
2:00-4:30 p.m.	Delegates' Registration	Convention Hall
6:00 p.m.	Blue Shield Board of Directors	Embassy Room
8:00 p.m.	Blue Shield Board, Dinner	Card Room
8:00 p.m.	Medicare Meditation Committee	Sky Room Lower

Thursday, May 12

All Day	Press Room	Room #116
All Day	Registration & Exhibits	Convention Hall
All Day	Staff Work Room	Room #115
All Day	Woman's Auxiliary Hospitality Room	Mezzanine Rm. 200A
8:00-9:30 a.m.	Delegates' Registration	Convention Hall Foyer
9:30 a.m.	First House of Delegates	Regency Room
10:00 a.m.	Auxiliary Registration and Pre-Convention Board Meeting	Mezzanine Theatre
11:00 a.m.	Blue Shield Annual Meeting	Regency Room
2:00 p.m.	Reference Committee #4	Regency Room
2:30 p.m.	Reference Committee #3	Seminar Room #2
3:00 p.m.	Reference Committee #2	Seminar Room #1
3:30 p.m.	Reference Committee #1	Seminar Room #3

Friday, May 13

All Day	Press Room	Room #116
All Day	Registration & Exhibits	Convention Hall
All Day	Woman's Auxiliary Hospitality Room	Mezzanine Rm. 200A
All Day	Staff Work Room	Room #115
8:00 a.m.	Board of Past Presidents, Breakfast	Sky Room Lower
9:00 a.m.	Scientific Session	Regency Room
11:00 a.m.	General Session (Baldwin Lecture)	Regency Room
12:15 p.m.	Committee on Scientific Work & Guest Speakers' Luncheon	Sky Room Lower
2:00 p.m.	Scientific Session	Regency Room
6:30 p.m.	President's Reception	Poolside / Alt. Regency or Lobby
7:30 p.m.	Alumni & Fraternity Groups: Emory	Embassy
8:00 p.m.	Florida Cancer Council	Sky Room (Upper)

Saturday, May 14

All Day	Press Room	Room #116
All Day	Registration & Exhibits	Convention Hall
All Day	Staff Work Room	Room #115
All Day	Woman's Auxiliary Hospitality Room	Mezzanine Rm. 200A

(Continued on page 330)

Saturday, May 14 (continued)

7:30 a.m.	Florida Association of General Surgeons, Council Breakfast	Les Ambassadeurs
9:00 a.m.	Florida Chapter, American College of Surgeons, Business and Scientific	Regency Room
9:00 a.m.	Florida Orthopedic Society, Scientific	Cafe Cristal
9:00 a.m.	Florida Radiological Society, Scientific	Mezzanine Theatre
9:00 a.m.	Florida Society of Ophthalmology & Otolaryngology, Eye Section, Scientific	Embassy East
9:00 a.m.	Florida Society of Ophthalmology & Otolaryngology, ENT Section, Scientific	Embassy West
9:00 a.m.	Florida Society of Pathologists, Business	Card Room
9:00 a.m.	Florida Health Officers' Society, Scientific	Sky Room Upper
9:00 a.m.	Florida Allergy Society, Business	Sky Room Lower
9:00 a.m.	Florida Society of Dermatology, Scientific	Rumpus Room East
9:00 a.m.	Florida Society of Physical Medicine and Rehabilitation, Business and Scientific	Seminar Room #1
9:00 a.m.	Florida Pediatric Society, Scientific	Seminar Room #2
9:00 am.	Florida Obstetric & Gynecologic Society, Business	Seminar Room #3
9:00 a.m.	Florida Society of Internal Medicine, Business	Tack Room
9:00 a.m.	Florida Society of Anesthesiologists, Board of Directors	Card Room West
9:00 a.m.	Florida Psychiatric Society, Business	Forum Room, Diplomat West
9:00 a.m.	Florida State Board of Health	Mr. Parham's Parlor
10:00 a.m.	Florida Proctologic Society, Business	Senate Room, Diplomat West
10:00 a.m.	Florida Obstetric & Gynecologic Society, Scientific	Seminar Room #3
10:30 a.m.	Florida Pediatric Society, Scientific	Seminar Room #2
11:00 a.m.	Florida Health Officers' Society, Business	Sky Room Upper
11:00 a.m.	Florida Society of Ophthalmology & Otolaryngology, ENT Section, Business	Embassy West
11:30 a.m.	Florida Society of Ophthalmology & Otolaryngology, Joint Business	Embassy East and West
11:30 a.m.	Florida Pediatric Society, Business	Seminar Room #2
12:10 p.m.	Florida Orthopedic Society, Business	Cafe Cristal
12:00 noon	Florida State Surgical Division, International College of Surgeons, Luncheon	Les Ambassadeurs
12:00 noon	Florida Society of Dermatology, Luncheon	Rumpus Room East
12:00 noon	Florida Society of Pathologists, Luncheon	Card Room
1:00 p.m.	Florida Society of Plastic & Reconstructive Surgery, Scientific	Seminar Room #3
1:30 p.m.	Florida Society of Dermatology, Business	Rumpus Room East
1:30 p.m.	Florida Society of Pathologists, Scientific	Card Room
2:00 p.m.	Florida Association of General Surgeons, Scientific	Regency Room
2:00 p.m.	Florida Academy of General Practice, Board of Directors	Sky Room Upper
2:00 p.m.	Florida Allergy Society, Scientific	Sky Room Lower
2:00 p.m.	Florida Urological Society, Business	Seminar Room #1
2:00 p.m.	Florida Neurosurgical Society, Business	Seminar Room #2
2:00 p.m.	Florida Chapter, American College of Chest Physicians, Scientific	Tack Room
2:00 p.m.	Florida Society of Anesthesiologists, Business	Card Room West
2:00 p.m.	Florida Psychiatric Society, Scientific	Forum Room, Diplomat West
2:30 p.m.	Florida Society of Plastic & Reconstructive Surgery, Business	Seminar Room #3
3:00 p.m.	Florida Urological Society, Scientific	Seminar Room #1
3:30 p.m.	Florida Neurosurgical Society, Scientific	Seminar Room #2
4:00 p.m.	Florida Radiological Society, Business	Mezzanine Theatre
4:00 p.m.	Florida Chapter, American College of Chest Physicians, Business	Tack Room
5:30 p.m.	Florida Urological Society, Cocktails	President's Suite (Robert J. Brown MD)
6:00 p.m.	Florida Chapter, American College of Surgeons, Cocktails	Regency Room
6:00 p.m.	Florida Orthopedic Society, Cocktails	Cafe Cristal
6:00 p.m.	Florida Society of Dermatology, Cocktails	Embassy East and West
6:30 p.m.	Florida Radiological Society, Cocktails	Mezzanine Theatre
6:30 p.m.	Florida Psychiatric Society, Cocktails with music	Forum Room, Diplomat West

(Continued on page 332)

Speakers Announced for Ninety-Second Annual Meeting



Dr. Harrison



Dr. Polk



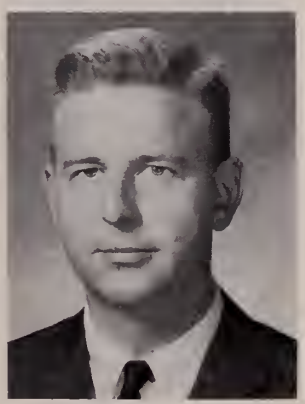
Dr. Slonim



Dr. Sommer



Dr. Kahana



Dr. Davidson



Dr. LaCamera



Dr. Carter

"The Yarmouth Castle Disaster (Further Experience in the Treatment of Large Human Burns with Aqueous Silver Nitrate (0.5%)," Hiram C. Polk Jr., M.D., Miami (9:00 a.m.) Friday, May 13.

"The School-Age Child With a Heart Murmur," Ralph Slonim, M.D., Miami, and Nora Belle Oldham, M.D., Miami. Presented by Dr. Oldham (by invitation). (9:10 a.m.) Friday, May 13.

"Endocrine Effects of Central Nervous System Lesions," Lawrence Kahana, M.D., Tampa (9:20 a.m.) Friday, May 13.

"The Management of Inoperable Breast Cancer by Endocrine Methods," Eugene T. Davidson, M.D., Lakeland (9:30 a.m.) Friday, May 13.

"Screen Tests for Metabolic Disorders in Newborn Infants," Charles H. Carter, M.D., Orlando (9:40 a.m.) Friday, May 13.

"Cineangiographic Evaluation of Valvular Insufficiency," Frank LaCamera Jr., M.D., St. Petersburg (9:50 a.m.) Friday, May 13.

"Idiopathic Ventricular Hypertrophy of the Heart," Leonard S. Sommer, M.D., Miami (10:00 a.m.) Friday, May 13.

"Varicose Vein Surgery in the Immediate Post-Partum Period," William H. Harrison Jr., M.D., Daytona Beach (10:10 a.m.) Friday, May 13.

Saturday, May 14 (continued)

7:00 p.m.	Florida Allergy Society, Cocktails	Sky Room Lower
7:00 p.m.	Florida Society of Pathologists, Cocktails	Card Room
7:30 p.m.	Florida Society of Dermatology, Dinner	Embassy East and West
8:00 p.m.	Florida Society of Pathologists, Dinner	Card Room

Sunday, May 15

Morning	Press Room	Room #116
Morning	Registration	Convention Hall
Morning	Staff Work Room	Room #115
7:30-9:30 a.m.	Delegates' Registration	Convention Hall
9:30 a.m.	Second House of Delegates	Regency Room
1:00 p.m.	Post-Convention Board of Governors Meeting, Luncheon	Embassy East

GUEST SPEAKERS



Dr. Hickam



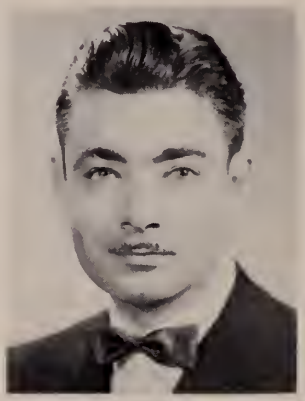
Dr. Wyatt



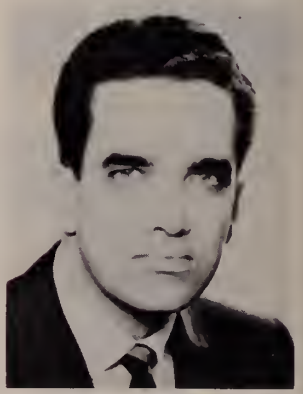
Dr. Ferguson



Dr. Waring



Dr. Matthews



Dr. Viamonte

"Management of Patients with Chronic Pulmonary Disease," John B. Hickam, M.D., Chairman, Department of Medicine, Indiana University School of Medicine, Indianapolis (2:00 p.m.) Friday, May 13.

"Pathogenesis of Emphysema," J. Poyner Wyatt, M.D., Associate Professor of Pathology, University of Manitoba Faculty of Medicine, Winnipeg, Manitoba, Canada (2:20 p.m.) Friday, May 13.

"Emergency Treatment of Chest Injuries," Thomas B. Ferguson, M.D., Associate Professor of Surgery, Washington University School of Medicine, St. Louis (2:40 p.m.) Friday, May 13.

"Antibiotic Therapy in Treatment of Childhood Pulmonary Disease," William W. Waring, M.D., Associate Professor of Pediatrics, Tulane University School of Medicine, New Orleans (3:00 p.m.) Friday, May 13.

"Inhalation and Physical Therapy of Chronic Obstructive Pulmonary Disease," LeRoy W. Matthews, M.D., Associate Professor of Pediatrics, Western Reserve University School of Medicine, Cleveland (3:30 p.m.) Friday, May 13.

"Clinical Use of Selective Bronchial Arteriography," Manuel Viamonte Jr., M.D., Associate Professor of Radiology, University of Miami School of Medicine, Miami (3:50 p.m.) Friday, May 13.



Government News

New PHS Legislation Expected

Editor's Note: The following information is abstracted from an article by Jonathan Spivak which appeared in the Wall Street Journal, January 19, 1966.

Surgeon General William Stewart, in an effort to make quality medical care available to all Americans, has as his immediate intent pulling together the nation's fragmented public health programs and plugging their gaps to produce an effective whole.

To this end, it's likely that new Federal legislation will be proposed this year to: (1) enable states to undertake broad-based health care planning, (2) substantially strengthen state health departments and, (3) funnel more funds into general health services rather than isolated efforts against specific ailments.

Proponents maintain costs may be kept at a minimum by extending and modifying several Public Health Service (PHS) programs scheduled to expire next July 1. They would like to almost double the $115 million a year in Federal funds now distributed to state and local health departments, mainly for medical services; but smaller increases accompanied by state and local reforms would permit extensive improvements, they insist.

Latent opposition from the medical profession is another potential PHS problem. Physicians do not quarrel with the comprehensive care concept, but organized medicine has always sought to limit the activities of state and local health departments to prevent encroachment on private practice.

To answer such questions, Federal officials will probably argue they are primarily seeking a way to spend existing funds, rather than a revolutionary expansion of Uncle Sam's responsibilities. They will stress, too, that public health usually serves people receiving inadequate medical care or none at all.

"The goal is clearly to make health services of good quality available to all Americans; it means comprehensive care," says Dr. Philip Lee, assistant Health-Education-Welfare secretary for medical affairs.

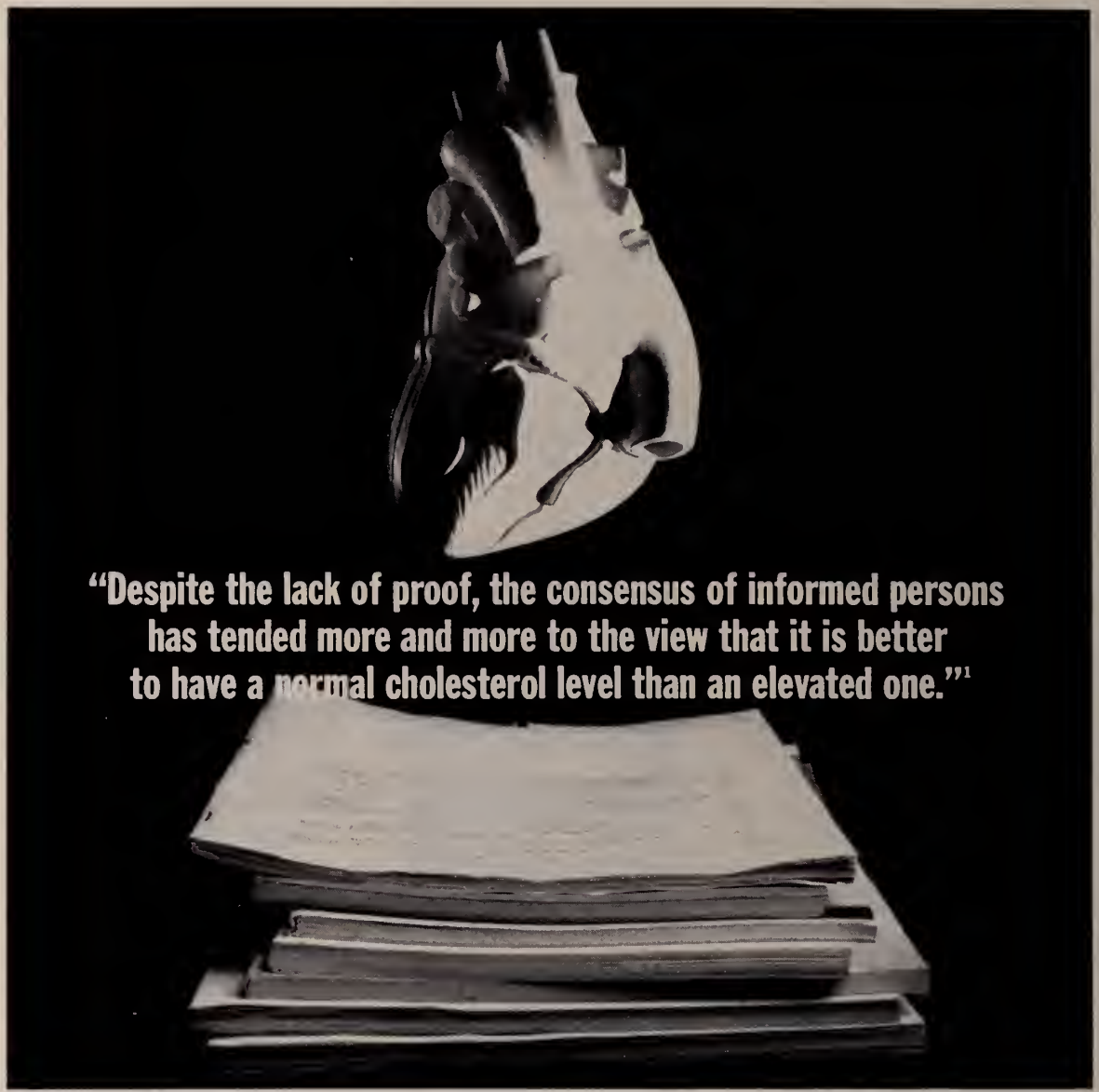
No single Washington step will unify all diverse health measures enacted in recent years. Thus, the HEW strategy will be to stress coordination at the state and local level and to promote the PHS as the Federal focal point for all health programs.

The PHS will undertake a rejuvenation of state health departments, considered the weakest link in the Federal-state-local public health chain. These units now receive $10 million a year from Washington. The PHS will seek to pump perhaps an added $20 million into the state agencies, enabling them to expand their activities.

Only a handful of state health departments, notably those in California, *Florida,* Maryland and New York, are rated even part-way prepared to provide the leadership now considered necessary.

PHS officials want to make major changes in their support of state and local health activities. Instead of earmarking Federal funds for specific purposes such as control of heart disease, tuberculosis or venereal disease, state health departments would be allowed to make their own allocations, thus allowing comprehensive care.

The PHS would also like wider authority to undertake efforts jointly with hospitals, medical schools or public health agencies to develop new, more flexible methods of delivering medical care to the community.



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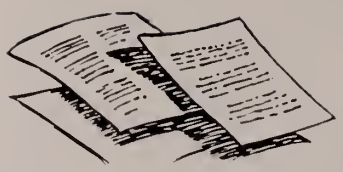
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Letters



February 17, 1966

Dear Dr. Moseley:

In reply to your letter of February 7, the following comments are submitted in response to the editorial by Dr. Prather.

The editorial by Dr. E. Charlton Prather in response to the paper "Intestinal Parasitism in South Florida" is indeed appreciated. It is heartening to know that the Director of the Division of Epidemiology of the Florida State Board of Health recognizes the importance of intestinal parasitism in Florida, but more importantly that he takes this opportunity to remind the medical profession that "we physicians tend to belittle the role of intestinal parasitism in human discomfort and disease."

In reply to the criticism regarding the prevalence of intestinal parasites in certain socioeconomic groups, may we point out that the statements indicating that the majority of cases referred to in both the Jackson Hospital and Regional Laboratory reports are from the middle to lower socioeconomic level were based upon personal communications from the respective sources. Unfortunately this was not verifiable by statistical data.

It is an erroneous assumption for the reader to think that all patients examined at Jackson Hospital for intestinal parasites belong to the lower socioeconomic group. This is a misinterpretation on the part of Dr. Prather. The information we have obtained is that this group predominates as far as examinations are concerned.

It is conceded that the incidence of intestinal parasitism is higher in children than adults and therefore would be a contributing factor in the

when abnormal capillary permeability and fragility are factors in

bleeding

in such conditions as:

habitual abortion

threatened abortion

purpura (nonthrombocytopenic)

gingivitis

dua

difference between an adult study group versus a mixed adult and children study group. Unfortunately the ratio of children to adults in the Jackson Hospital and Regional Laboratory reports is not known and therefore the degree to which children influenced the incidence rate is unknown. In emphasizing the significance of age differences Dr. Prather has erroneously stated that stool examinations are "routine" for all admissions to the Pediatrics Service at Jackson Hospital. We have been informed to the contrary. Whether or not this practice applies at all public health clinics in Florida, as indicated by Dr. Prather, we are unable to say.

We concur with Dr. Prather that studies from the Caribbean area and Latin America should have been included. At the time of writing the paper, however, we felt that it should be restricted to the South Florida area. To fill this void in part it may be stated that one of us during a recent study in one of the Central American countries learned from the Department of Public Health of that country that a survey for intestinal parasites among several thousand school children revealed an incidence of approximately 98%. This study was based on the examination of only one stool specimen per patient. In a study in Jamaica (Beck, 1960) an incidence of 30.4% amebiasis was recorded in a small rural village. Other workers in Jamaica have likewise substantiated this figure. Grant, et al (1963) in a drug evaluation study of approximately 2,000 people reported an incidence of Ascaris lumbricoides 47%, hookworm 28% and Trichuris Trichiura 32%. These are the "unholy three" of the tropics and, along with Entamoeba histolytica, the causative agent of amebiasis, represent the most important intestinal parasites of the tropics in this hemisphere. Beck, et al (1965) in a study in Cartagena, Colombia, worked in a small village and of a total of 235 persons examined found all to be infected with one or more parasites. Ages ranged from 4 to 73.

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Frightening though this information is, it must be pointed out that the extent to which travelers from the United States become infected is conditioned by the socioeconomic level at which they travel and live. A tourist, for example, living in a plush hotel in Montego Bay, Jamaica, dining only in the best restaurants and returning to home base in the evening after a tour of the countryside during which time he has avoided native foods and local water, remains reasonably safe from intestinal parasites. On the other hand, the more adventuresome individual who goes "native" will in all probability soon become like the natives as far as infection is concerned. Likewise, anyone remaining for a sustained period of time invariably lets down some of the precautionary barriers and ends up with one or more uninvited guests.

Though not germaine to the topic it would seem most appropriate at this time to call the attention of the reader to the danger of swimming or wading in many fresh water streams of some of the Caribbean Islands. Schistosoma mansoni, the blood fluke causing schistosomiasis in man, is acquired by the skin penetration of the cercariae (larvae) which are shed in the water by infected snails of the genus Australorbis glabratus. The first case to our knowledge in recent times was a physician and family from the United States on a Caribbean jaunt through the West Indies.

In conclusion we sincerely hope that everyone will remember that, as Dr. Prather has pointed out: "The common, old fashioned, unpopular, 'worms' are still with us. May we never become complacent about them."

References

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Grant, L.; Beck, J. W.; Chen, W. N., and Belle, E. A.: A Survey of Parasitic Infection in Two Communities in Jamaica and a Drug Trial on Positive Cases, W. I. Med. J. 12:185-193, 1963.

Beck, J. W.; Garcia-Laverde, A; Hartog, E. M., and Shaner, A. L.: Empleo de la Technica de Recuento de Huevas de Ritchie-Frick en el Estudio de la Efectividad del Antihelmintico Monopar (Yoduro de Stilbazium), Rev. Facultad Med. 33:33-36, 1965.

Sincerely yours,

J. Walter Beck, Ph.D.

Frederick E. Farrer, M.D.

Miami



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(Continued from page 304)

An elevated serum bilirubin, an alkaline phosphatase above 8 or 10 Bodansky units, and the absence of urobilinogen in the urine are very strong evidences that one is dealing with a problem of surgical jaundice. Normal protein, serum glutamic oxaloacetic transaminase. (SGOT) and prothrombin time, to mention a few, help to substantiate this diagnosis. The cholecystogram and the intravenous cholangiogram are not dependable in the face of jaundice and I do not waste the patient's funds pursuing these. The upper gastrointestinal series may give some help in identifying a pancreatic lesion. Also, study of the colon may reveal a primary tumor.

Having excluded the nonsurgical causes of jaundice, the second phase of the diagnosis is basically the surgical exploration. To perform only a cholecystectomy because there are stones in the gallbladder is not the intelligent approach to the jaundiced patient. A complete exploration of the abdomen must be performed before any irreparable surgical therapy is undertaken. All too often a patient who has been known to have gallstones is subjected to an exploratory operation because he is now jaundiced, only to find carcinoma, either primary or metastatic, obstructing the biliary tree or infiltrating the liver. Complete exploration entails examination of the stomach and bowel to exclude a tumor, visualization of the liver and pancreas to evaluate the possibility of cirrhosis, hepatitis or pancreatitis, and evaluation of the common bile duct and gallbladder.

In the face of jaundice the common bile duct must be explored and it is good practice to include an operative cholangiogram in addition to probing and lavaging the duct.

At this point, having excluded causes of jaundice originating outside the biliary tract, one is in the most favorable position to establish the exact cause of the patient's jaundice, and the appropriate surgical treatment can be performed to correct the problem.

In summary, the approach to the diagnosis of surgical jaundice has a preoperative and an operative component. The thoroughness with which both of these are performed will yield the greatest number of correct diagnoses and permanent cures.

Questions

Dr. Kalser.—Dr. Hilf, how much personal experience have you had with transhepatic cholangiography? Do you perform the procedure unless you plan immediate operation?

Dr. Hilf.—The procedure is never performed on a patient unless it is thought that he could tolerate exploratory celiotomy and should be undertaken with exploration planned sometime within the following 12 hours. I have found the procedure useful on several occasions in excluding extrahepatic obstruction.

Dr. Kalser.—Here at the University, we are evaluating the technique and are routinely following the procedure with surgical exploration. To date, we have encountered three instances of inability to puncture a dilated bile duct in patients with extrahepatic obstruction. Ideally, one would like to feel confident that if our attempts at aspiration of a bile duct are unsuccessful, extrahepatic obstruction is not present and operation can be postponed.

A Student.—Can the use of steroids to suppress bilirubin concentrations always distinguish intrahepatic from extrahepatic obstructive jaundice?

Dr. Rogers.—The suppression test is most useful in differentiating intrahepatic obstruction secondary to viruses from any form of extrahepatic obstruction; drug jaundice may not respond to the steroid test. A few false positive and false negative results occasionally are observed.

A Student.—No one mentioned the use of Vitamin K analogues in separating parenchymal from extrahepatic obstructive jaundice. Is this still used?

Dr. Kalser.—I am glad you mentioned this commonly overlooked "challenge" test. In fact, it may be very useful and we have found it to be so on more than several occasions. If, following the intramuscular administration of 25 mg. of phytonadione (Mephyton) on two successive days, the abnormal prothrombin time returns significantly toward or to normal, extrahepatic obstruction was the most likely cause of the original prolongation. If there is little or no improve-

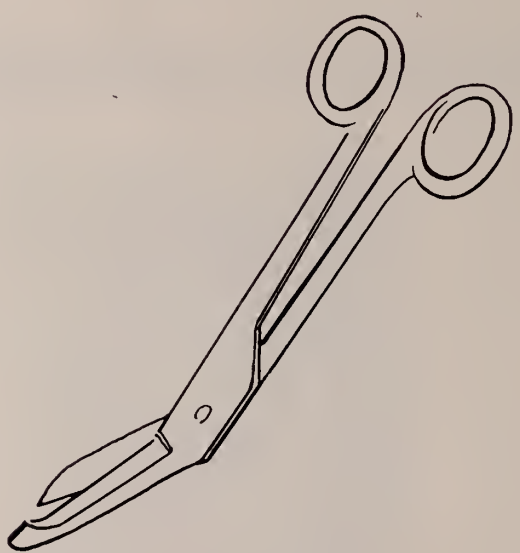
ment toward normal, there is underlying parenchymal disease at the basis of the prolonged prothrombin time.

A Student.—Dr. Gilbert, is the basis for the jaundice usually obvious on exploration?

Dr. Gilbert.—It may or may not be. A large distended gallbladder associated with a dilated common duct demands a search of the pancreas. Metastatic lesions in the liver should occasion a search at the hepatic duct bifurcation for node compression or duct infiltration and a thorough search of the remaining viscera for a primary lesion. Finding no apparent cause for the jaundice should remind the surgeon to palpate carefully the hepatic ducts for primary carcinoma, particularly the left one, before ruling out surgical jaundice. A liver biopsy should be performed when feasible.

Dr. Kalser.—If there are no further questions, the conference is concluded. Thank you for coming.

▶ Drs. Rogers, Kalser, Harkness, Hilf and Gilbert, University of Miami School of Medicine, Jackson Memorial Hospital, Miami 33136



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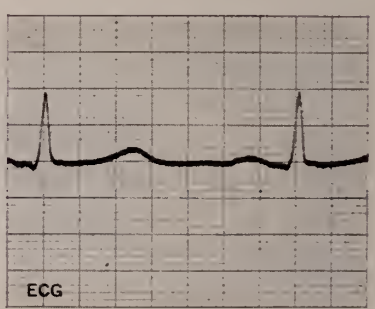
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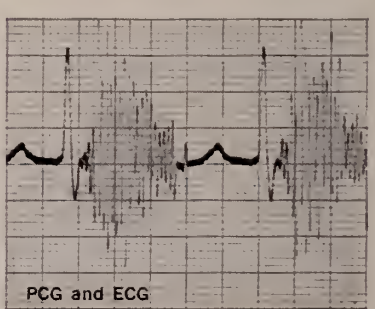
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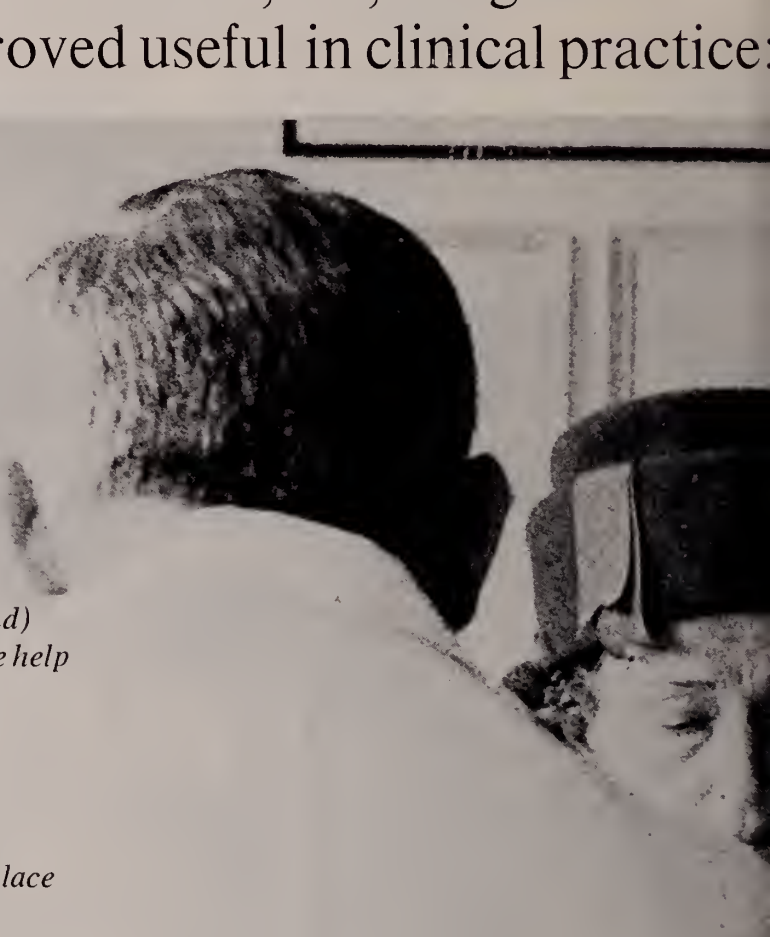
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McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

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Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

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Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

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Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.

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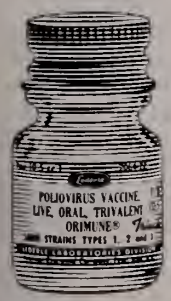
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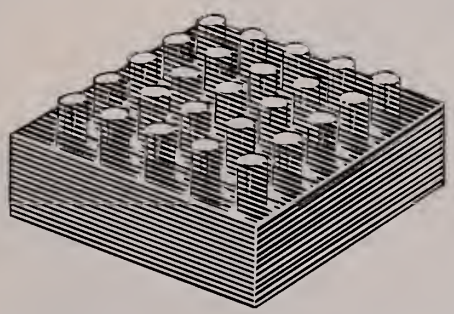


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*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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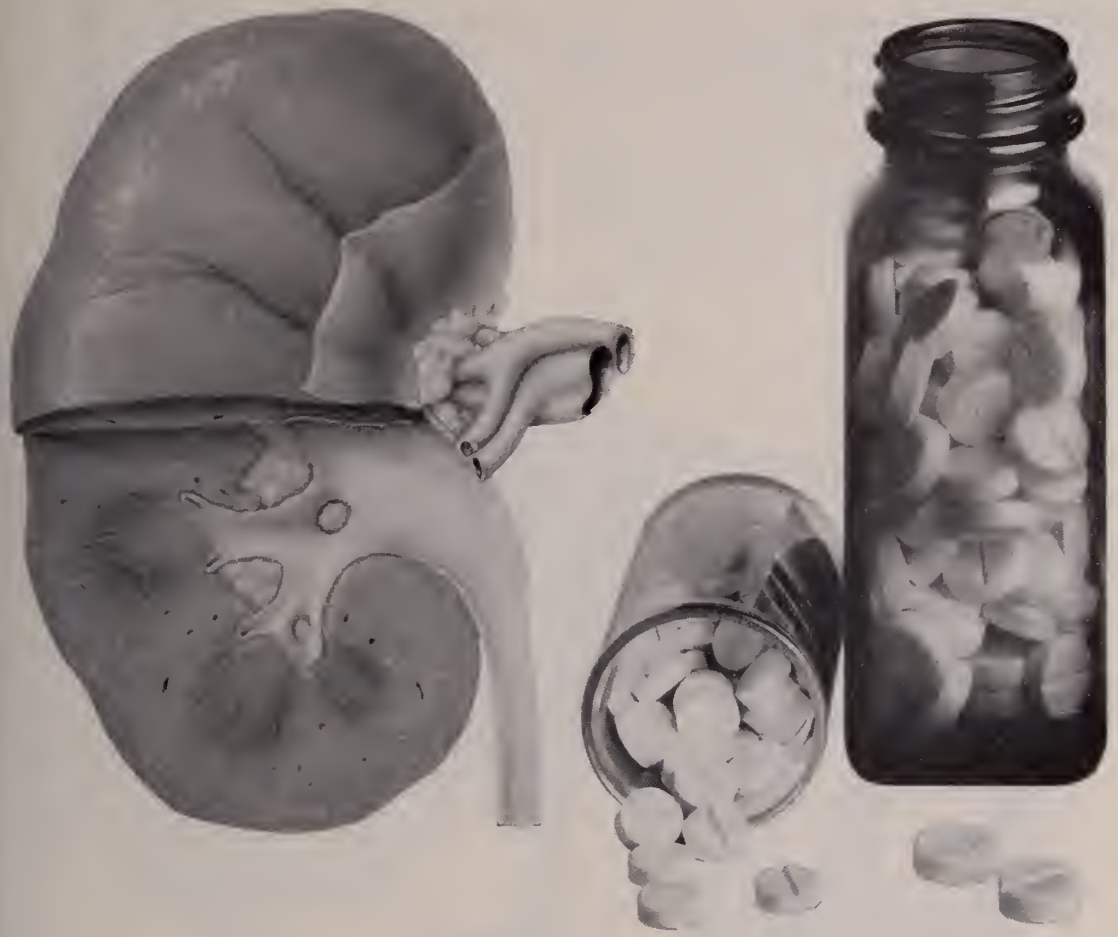
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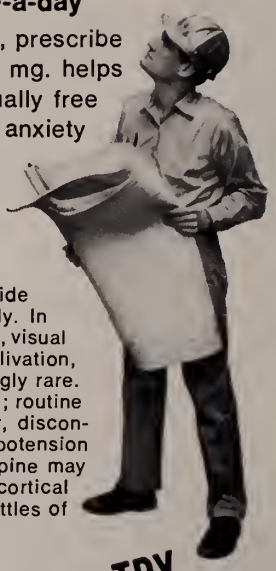
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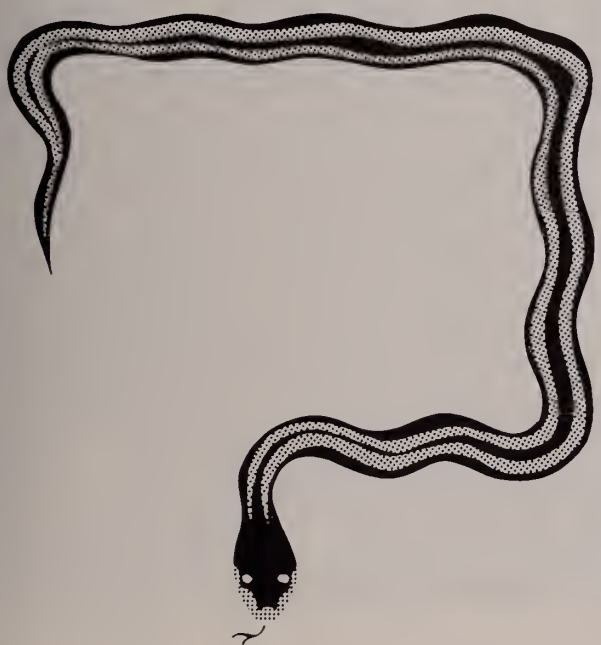
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1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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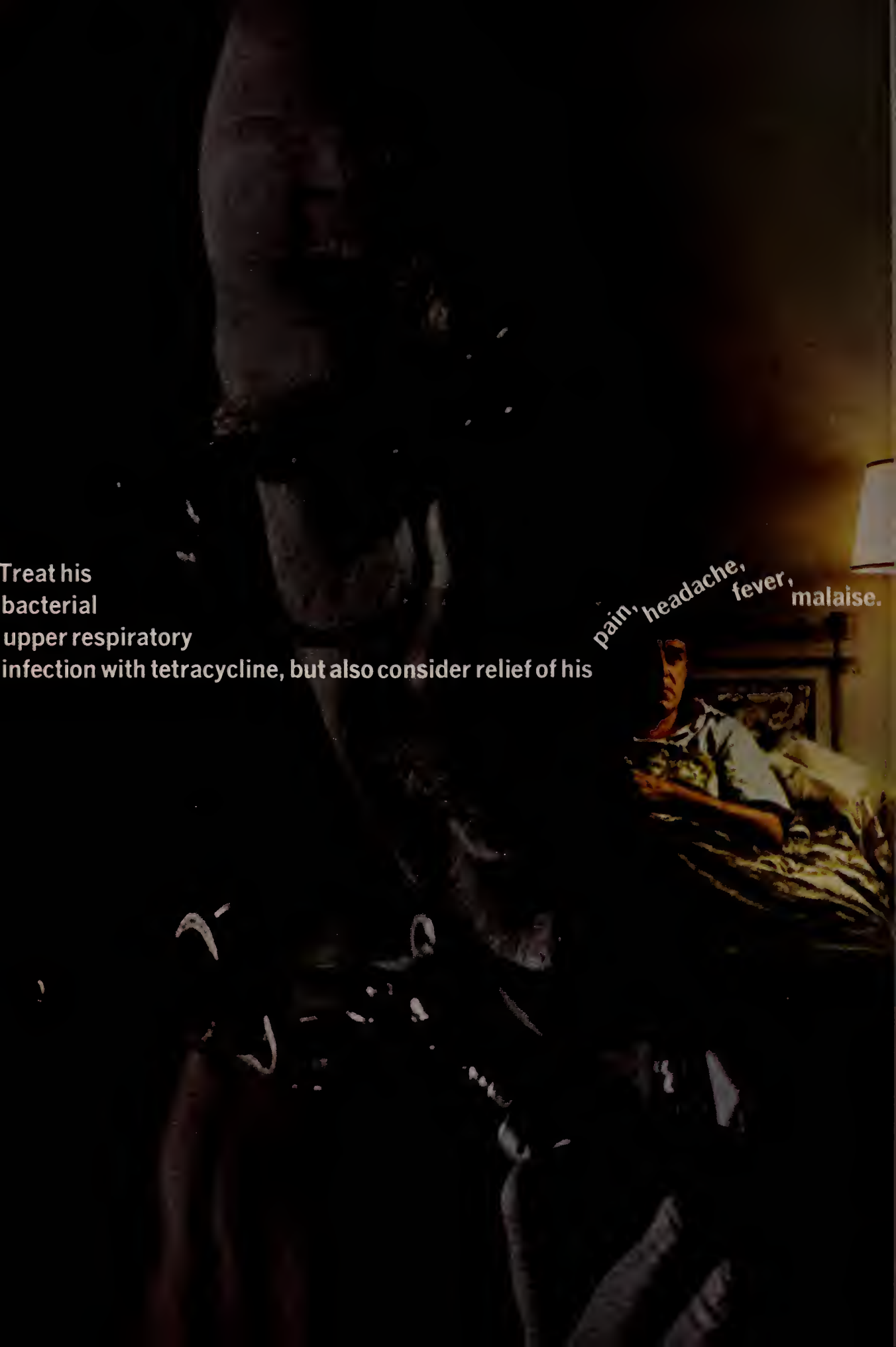
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ks, V., and Dawson, A.: M. J. 1:293, 1965.

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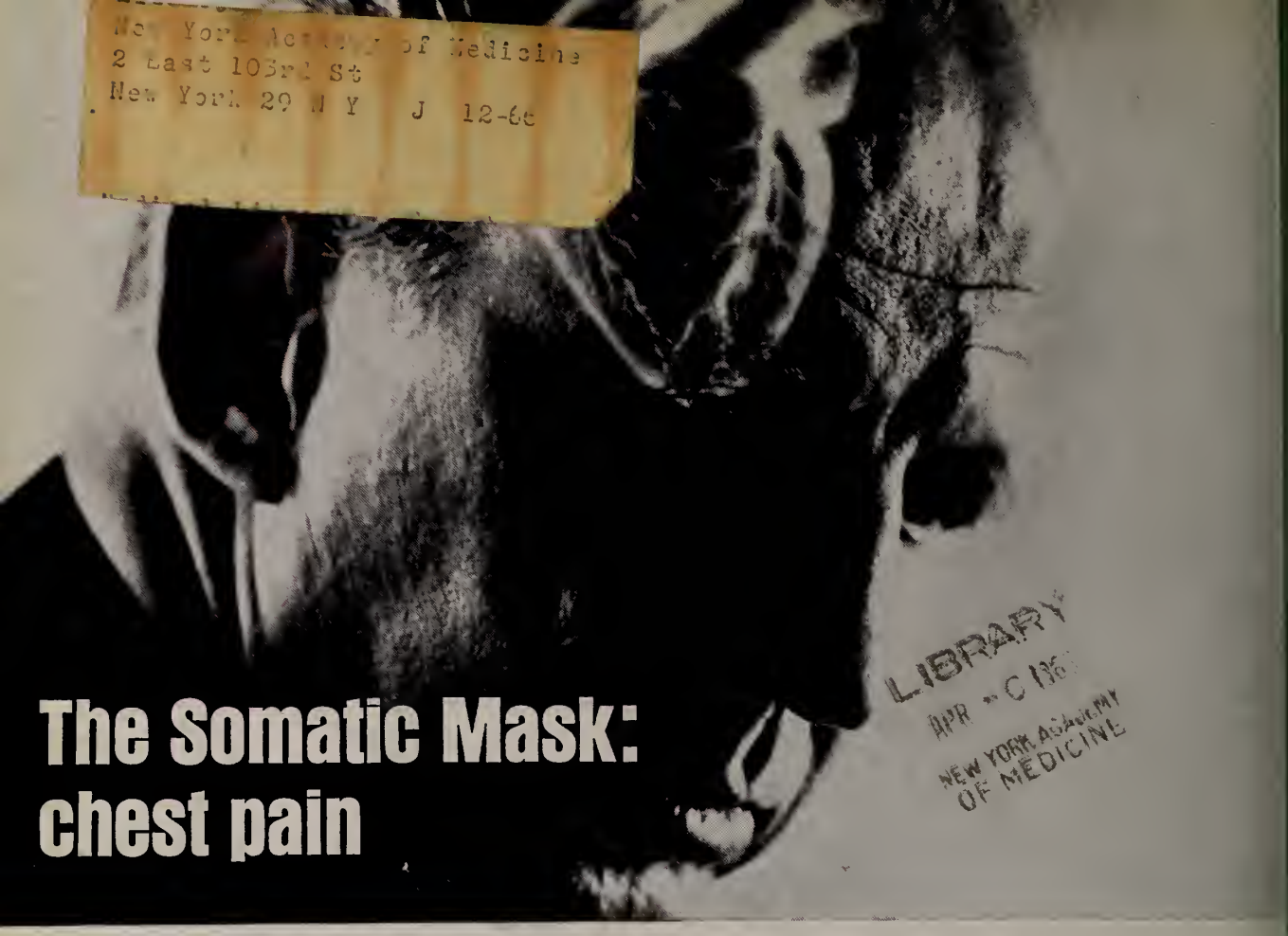
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The Somatic Mask: chest pain

heart disease or psychic tension?

"Heart symptoms"—chest pain, tachycardia, arrhythmia—invariably alarm and preoccupy the patient, though they may be completely without organic basis. Such symptoms often are somatic masks of psychic tension, arising from constant encounters with stressful situations.

When the problem is diagnosed as emotionally produced, consider Valium (diazepam) as adjunctive therapy. Valium (diazepam) acts rapidly to calm the patient, to reduce his psychic tension and relieve associated cardiovascular complaints.

Neurotic fatigue—the chronic tiredness resulting from emotional strain which so often accompanies psychogenic "heart" symptoms—also can be controlled by this highly useful agent. Valium (diazepam) often achieves results where other psychotherapeutic agents have failed.

Valium (diazepam) is generally well tolerated, and usually does not impair mental acuity or ability to function. If side effects such as ataxia and drowsiness occur, they usually disappear with dosage adjustment.

In prescribing: Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. q.i.d. in first 24 hrs, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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MAY, 1966
Volume 53
Number 5

The JOURNAL of the Florida Medical Association

IN THIS ISSUE

M. D. Candidates for Legislature
Home Care Program
Acute Brain Syndrome
Management of Anxiety
Duplication of the Stomach
Clinicopathological Conference
Calcified Cyst of Adrenal Gland

OFFICIAL PUBLICATION
M D
OF THE
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MEDICAL ASSOCIATION

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92nd Annual Meeting, May 12-15

Diplomat Hotel, Hollywood Beach

INDICATIONS: Grand mal epilepsy and certain other convulsive states.

PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced.

SIDE EFFECTS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Upon discontinuation of therapy eruptions usually subside. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Hematologic disorders, including megaloblastic anemia, leukopenia, granulocytopenia, pancytopenia, and aplastic anemia have been reported. Nystagmus may develop.

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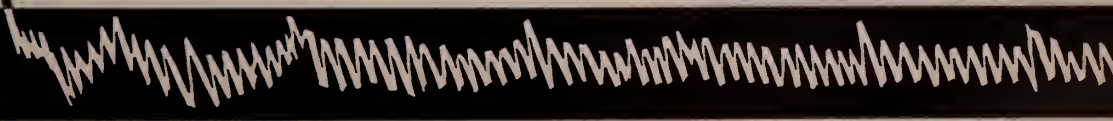
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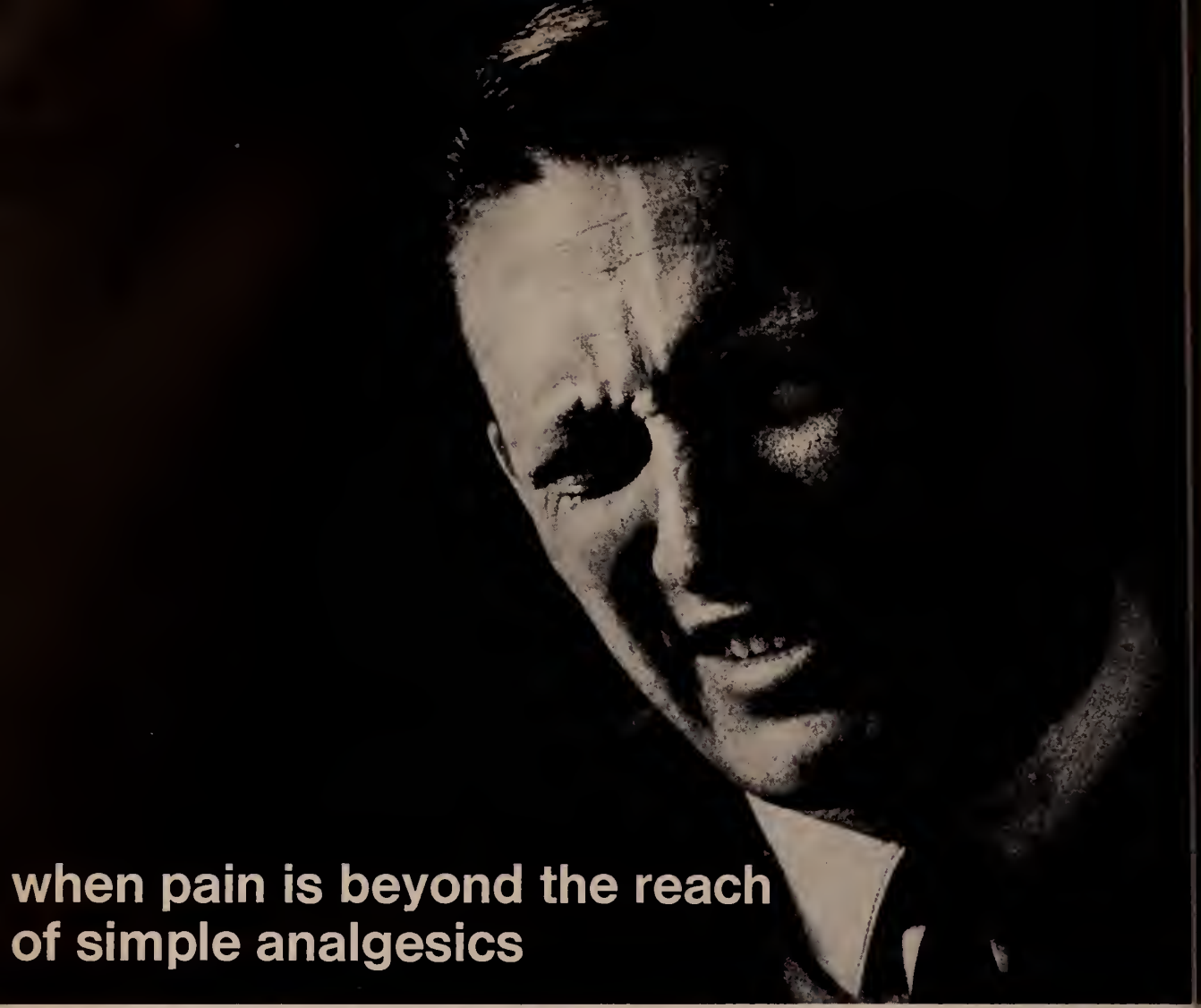
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Side effects have been minor. Occasionally gastric distress, weakness, sedation or dizziness occur. Reversible choleste jaundice has been reported on rare occasions. However, in 4,653 patients treated with chlormezanone, 97.7% had *no* s effects.[1] *Contraindication:* just one: sensitivity to aspirin. *Dosage:* Adults, usually 2 tablets three or four times daily. Children (from 5 to 12 years), 1 tablet three or four times da

1. Collective studies, Department of Medical Research, Winthrop Laboratories.

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of the Florida Medical Association

Volume 53, Number 5, May 1966

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Anatomy of
Low Back Pain #1



the sedentary life is often the seat of low back pain

The human spine is not engineer
prolonged sitting at desks, pianos
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set up by the heavy, forward-tilte
and trunk, balanced precariously
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dorsal musculature, particularly
low lumbar level.

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loskeletal conditions. It also may act to nc
motor activity in certain neurologic distur

Contraindications: Allergic or idiosyncrat
tions to carisoprodol.

Precautions: 'Soma', like other central
system depressants, should be used with
in patients with known propensity for tak
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known sensitivity to compounds of similar
cal structure, e.g., meprobamate.

Side Effects: The only side effect reported v
frequency is sleepiness, usually on high
recommended doses. An occasional patie
not tolerate carisoprodol because of an in
reaction, such as a sensation of weakness
rarely observed reactions have included di
ataxia, tremor, agitation, irritability, heada
crease in eosinophil count, flushing of fa
gastrointestinal symptoms.

One instance each of pancytopenia and
penia, occurring when carisoprodol was
istered with other drugs, has been reported
an instance of fixed drug eruption with caris
and subsequent cross reaction to meprot
Rare allergic reactions, usually mild, have ir
one case each of anaphylactoid reaction wi
shock and angioneurotic edema with res
difficulty, both reversed with appropriate t
In cases of allergic or hypersensitivity re
carisoprodol should be discontinued and ap
ate therapy initiated. Suicidal attempts m
duce coma and/or mild shock and resp
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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

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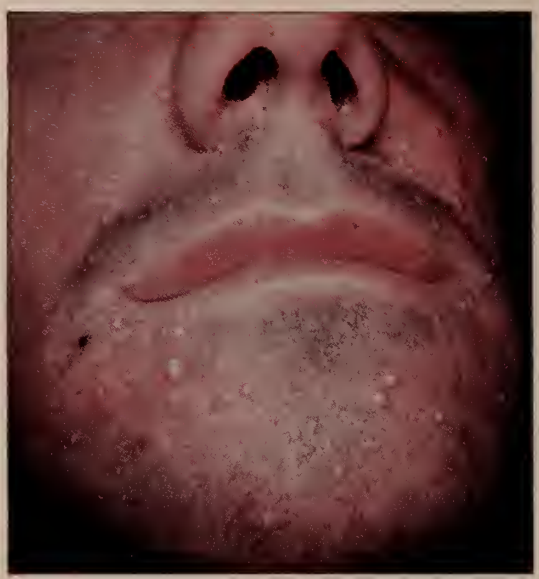
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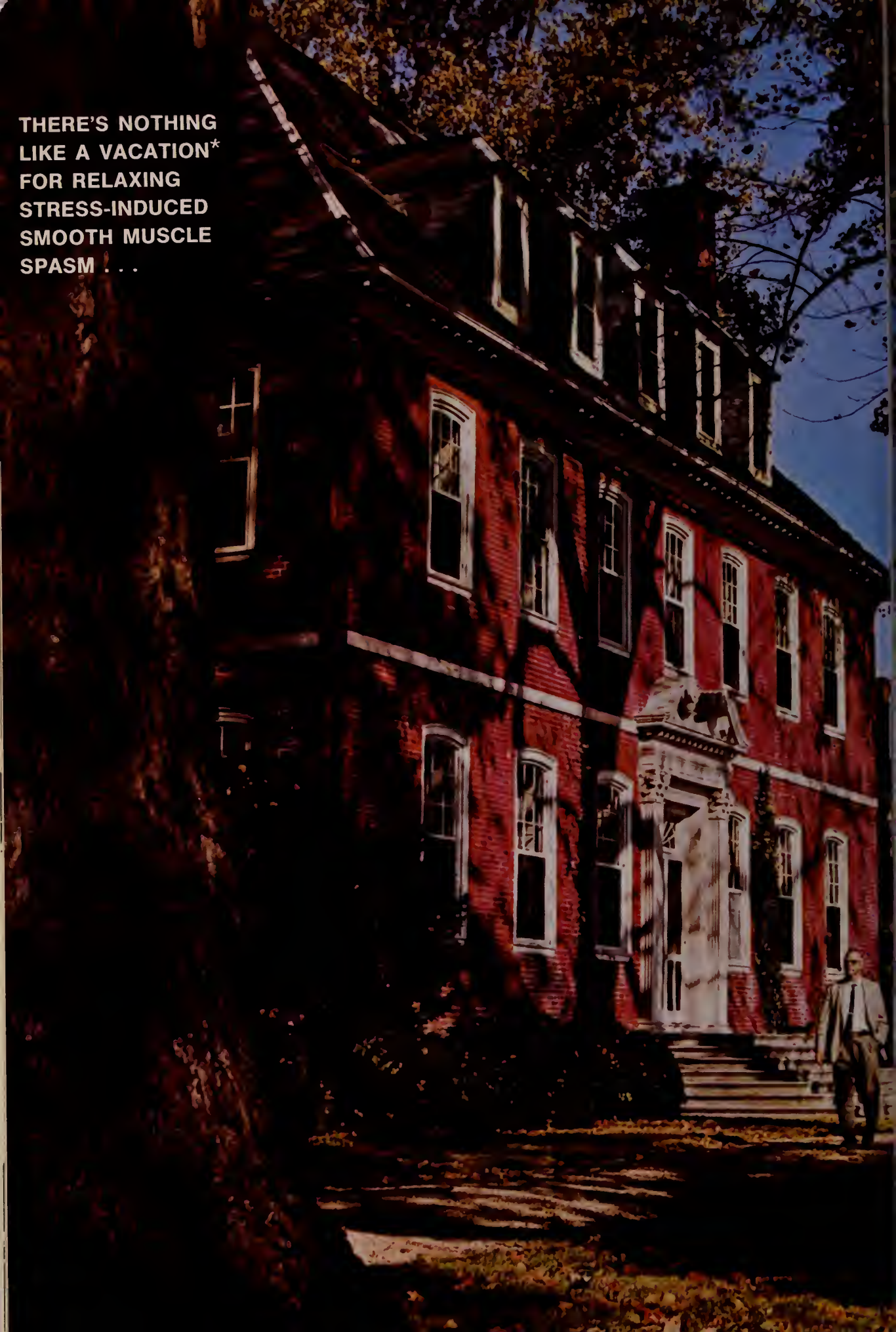
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hyoscine hydrobromide ...	0.0065 mg.
phenobarbital	(1/4 gr.) 16.2 mg.

(warning: may be habit forming)

IN EACH EXTENTAB

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atropine sulfate	0.0582 mg.
hyoscine hydrobromide ...	0.0195 mg.
phenobarbital	(3/4 gr.) 48.6 mg.

(warning: may be habit forming)

BRIEF SUMMARY: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma, or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease, or a hypersensitivity to any of the ingredients.

REFERENCES: 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

*This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

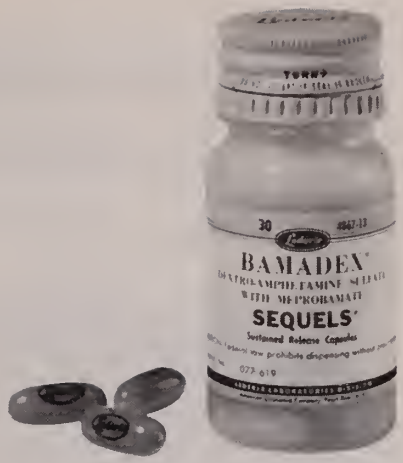
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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Usual Adult Dosage: 1 capsule q.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals.
Supply: Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. Oral Suspension, 60-ml. bottle. Each 5 ml. contains tetracycline equivalent to 125 mg. tetracycline hydrochloride and nystatin, 125,000 units.

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The JOURNAL
of the Florida Medical Association

Home Care Program
A Two Year Clinical Evaluation

JEROME B. SHAPIRO, M.D. and JEAN JONES PERDUE, M.D.*

Chronic illnesses need long time management, for which home care programs would be of benefit. The following is a review of experience gained in one such program between June 1963 and June 1965.

Description of Program

The working team consisted of a physician, a visiting nurse, and a social worker. Consultation services were readily available. If the patient could no longer be managed at home, direct admission to a hospital or nursing home could be accomplished.

Because of limited personnel, certain criteria were established before admission to the program. These were: (1) the patient had to have a disorder manageable at home and did not require hospitalization, (2) the patient was unable to attend the outpatient clinic, (3) there was a responsible person at home who could and would assume responsibility for the patient, and (4) the patient desired home care.

The basic goals of the program were: (1) to furnish the best medical care for the patient and his family and (2) to reduce its cost.

*Director, Continuing Patient Care Division, Jackson Memorial Hospital.

Routine house calls were made by each of the team members. Twenty-four hour coverage was supplied and the patient could contact his physician by telephone at any time. Medications were either supplied from a local pharmacy or the hospital.

See editorial comment page 421

Although only 70 cases are reviewed, many more were seen. The others were not included because: (1) they involved mostly a nonmedical problem, or (2) the stay of the patients on the program was so short, usually under one week, that the benefit of the program was questionable. The latter usually included those who were inappropriately referred, since they were better managed in an outpatient clinic, or those with terminal disease, who died within one week of referral.

Results

Patient Population.—Of the 70 patients, 38 were men and 32 women with ages ranging from 13 to 95 years. The vast majority were 50 to 90 years of age. Twenty were Negro patients and 50 white patients.

Type of Cases.—The cases were broadly classified into five disease groups: (1) musculoskeletal, (2) neuropsychiatric, (3) cancer, (4) cardiovascular, and (5) miscellaneous. Table 1 shows the number of cases in each category with the age distribution. The majority fell into the musculoskeletal, neuropsychiatric and cancer categories, as would be expected because they produce the largest percentage of bedridden chronic illnesses.

Most of the musculoskeletal conditions were due to either rheumatoid arthritis, degenerative arthritis or fracture of a hip. The neuropsychiatric conditions were mostly strokes and chronic brain syndromes due to cerebral arteriosclerosis. The cancer patients had reached a metastatic stage and were beyond palliative treatment.

Length of Stay.—The length of stay in the program depended mainly upon the medical condition. Patients with cancer were on the program for only a short period of time, usually under two months, before death occurred. Patients with chronic brain syndromes also were on the program for a short period of time, usually because the family would find them too difficult to manage at home.

Four out of seven patients with rheumatoid arthritis were discharged from the program to the outpatient clinic. Most of the other patients with musculoskeletal, neurologic and miscellaneous diseases remained on the program for a prolonged period of time, since they had slowly progressive diseases.

Medical Problems.—Since all had a chronic medical disease, their condition when admitted to the program was usually stable. Most had medical disorders for which there was no specific treatment but only supportive care. Emotional problems were common. Most cancer patients knew the diagnosis of their disease, and that death was imminent. They often requested to be allowed

Table 1. — Classification of Cases

Group	Disease	Number of Patients	Age Range
Musculoskeletal	Rheumatoid arthritis	7	21-68
	Fractured hip	5	70-95
	Degenerative arthritis	3	72-92
	Herniated disc	1	55
	Total	16	
Neuropsychiatric	Stroke	9	49-79
	Chronic brain syndrome	8	60-80
	Cerebral palsy	1	50
	Dystonia myotonia congenita	1	32
	Multiple sclerosis	1	38
	Post encephalitis	1	39
	Friedreich's ataxia	2	21-22
	Amyotrophic lateral sclerosis	1	57
	Depressive reaction	1	80
	Total	25	
Cancer	Gastrointestinal tract	12	53-89
	Respiratory	2	54-55
	Genitourinary	7	26-78
	Total	21	
Cardiovascular	Venous insufficiency	1	81
	Stokes-Adams	1	82
	Arteriosclerotic heart disease	1	87
	Arteriosclerosis obliterans	1	76
	Total	4	
Miscellaneous			
	Bronchiectasis	1	44
	Emphysema	1	89
	Diabetes mellitus	1	13
	Adiposis dolorosa	1	64
	Total	4	

to die at home and wished not to return to the hospital. The main problem was to make them as comfortable as possible by relieving their pain and anxieties. The home use of narcotics presented no problems, but tolerance to the drugs developed quickly. When injectable narcotics were necessary, a member of the family was then trained to give the medication. Records of the amount used were maintained to prevent abuse. Phenothiazines, especially chlorpromazine, helped allay anxieties and potentiate the effect of narcotics. Depression did not seem to be a factor in these patients and the few treated with amitriptyline gained little benefit.

In many other patients with a chronic disease not life-threatening, depression often developed. This was the one emotional condition which had to be anticipated, for an antidepressant such as amitriptyline was beneficial in many cases.

Two other problems were constipation and urinary tract infection. The prevention of constipation was usually accomplished by the use of laxatives or enemas given by a visiting nurse. The patients had to be constantly encouraged to drink fluids, especially during the summer months. Urinary tract infections were treated with appropriate antibiotics.

Winter presented the problem of pneumonia in the bedridden, especially those with chronic lung diseases. A broad spectrum antibiotic such as tetracycline or ampicillin, given at the first sign of an infection of the upper respiratory tract, helped, and with these patients no episodes of pneumonia occurred.

Two patients with a tracheostomy were managed without difficulty. Also others with indwelling bladder catheters presented no problems provided fluid intake and proper drainage were maintained by responsible members of the family who had been instructed in proper maintenance. Feeding through nasogastric tubes did not work well at home because of aspiration.

Visits.—Initially several weekly visits had to be made to assure optimum medical supervision and that the patient's condition was stable. Thereafter, monthly visits were usually sufficient. To make visits less often usually alarmed the patient and/or his family.

Emergency visits were seldom requested. They were sought usually because of diarrhea, respiratory infection, a fall or an emotional problem. Admission to the hospital and referral to the hospital for consultations thereafter were relatively uncommon.

Discussion

The benefits to both the patient and the community from caring for chronic illnesses at home are obvious: better medical care and more efficient and economical treatment of the patient. Without this program most patients would need a nursing home or frequent hospitalization.

Medically they present few problems for home care. The most important factor is the presence of a stable, sincere person at home to care for the patient. This is usually a member of the immediate family such as a wife, husband, or mother. Once offered the assurance of continued medical support, the relative is willing to assume care of the patient. The foundation of this assurance is (1) availability of a physician 24 hours a day, (2) availability of a nurse to assist with nursing needs and to give injections, (3) adequate financial assistance to meet day to day needs and supply extra domestic help if needed, and (4) availability of drugs and appliances as needed.

Although the condition of most of these patients appears hopeless and terminal, the medical management may be rewarding. Death at home allows patients with terminal illness to stay where they wish to be. At home these patients receive better nursing care, and although they are bedridden, bed sores seldom develop. An obese diabetic woman was the only one of the 70 patients in this series in whom a bedsore developed.

In the presence of family and friends patients stay more mentally alert and active. When depression appears, with treatment a good response is usually achieved, and a dramatic improvement is often seen.

When patients are at home, feelings of guilt, by members of the family with relatives placed in a nursing home, are arrested.

Summary

Two years' experience as a physician with a home care program dealing with chronic illnesses at a large county hospital is reviewed. The types of patients, their medical problems, and their management are discussed. It is thought that such a program offers many advantages to both the patient and his community.

▶ Dr. Shapiro, 10531 South Dixie Highway, Kendall 33156

Calcified Cyst of Adrenal Gland

EMMET FERGUSON JR., M.D., NORMAN H. LEFFLER, M.D.,
C. T. MONTGOMERY, M.D., and RICHARD BEAN, M.D.

The rarity of adrenal cyst is attested by the fact that only 170 cases have been reported in the literature to date.[1,3,8,9] This condition was first reported in 1670 by Greiselius.[2] Since symptomatology and diagnostic laboratory studies are not specific, the correct preoperative diagnosis is seldom made;[3] and, in fact, Palubinskas[4] suggested that the rarity is due more to the clinical silence of the lesion than to its true rarity. The lesion is reported in all age groups from the newborn[5] to old age, but reaches a peak incidence in the fifth decade.[6] It may be present on either side with equal incidence and may be bilateral in a small percentage of cases.[7] The lesion is reported to be twice as common in the female.[6]

Report of Case

A 37 year old white housewife was admitted to Baptist Memorial Hospital on June 4, 1964 with a chief complaint of pain in the right side of the back for the past month radiating down the right leg. Associated complaints were suprapubic and epigastric pain, nausea and dizziness. A medically managed duodenal ulcer had been present for the past four years. No history of previous trauma or severe illness was elicited. Two years prior to admission, the patient was hospitalized with a complaint of pain, weakness and numbness of the left leg. Neurological evaluation gave negative results and a diagnosis of conversion hysteria was made. The family history and review of systems were noncontributory. The positive physical findings included tenderness on the right side in the region of the costovertebral angle and the epigastrium, with a questionable mass in the right upper quadrant of the abdomen and spasms of the paravertebral musculature on the right side.

Jacksonville Hospital Education Program, Baptist Memorial Hospital.

Laboratory Data.—A hemogram, urinalysis, serum amylase, fasting blood sugar, blood urea nitrogen, sedimentation rate, alkaline phosphatase, cholesterol, and serologic tests all gave results within normal limits. A roentgenogram of the abdomen revealed a symmetrically rounded opacity of the inferior border of the liver. When viewed retrospectively, following an intravenous pyelogram, definite calcification was noted in the medial wall of the rounded mass. The intravenous pyelogram showed minimal ptosis and malrotation of the right kidney with prompt bilateral visualization of the collecting system. Gallbladder examinations showed displacement of the gallbladder across the midline to the left upper quadrant (fig. 1). Roentgenograms of the upper gastrointestinal tract revealed hypertrophy and deformity of the duodenal bulb with active duodenal ulcer crater. A retrograde pyelogram showed displacement of the right kidney inferiorly by a large mass, lying inferior and in proximity to the liver. The roentgenologist stated that this was most likely an adrenal cyst, basing his diagnosis on the thin rim of calcium in the medial wall of the mass.

Laparotomy Findings.—At operation, on June 12, 1964, a globular, cystic, grayish-bluish mass containing thin, milky fluid was encountered. It measured 10 by 15 by 15 cm. At first, it was thought that the mass was a lipoma. Upon puncture, however, the cyst contained approximately 1½ liters of thin milky fluid with heavy spicules of calcium protruding from the cyst wall. Further dissection revealed that the cyst arose from the retroperitoneal area and was adherent to the adrenal gland. The cyst was removed, and also one fifth of the right adrenal gland.

Postoperative Course.—The patient recovered uneventfully and was discharged on the sixth postoperative day. Routine follow-up revealed that the patient was asymptomatic four months after the operation.

Pathologic Findings.—The gross specimen consisted of a collapsed cystic mass measuring 13 cm. in its greatest diameter with a slightly roughened hemorrhagic area on the external aspect. A 7 cm. piece of tissue had adrenal gland characteristics. There were small areas of calcified spicules on the internal wall of the cyst. Microscopically, the cyst wall consisted mainly of hyalinized and fibrous tissue with numerous areas of calcification on the internal surface. The external surface showed adrenal tissue with many regions of adrenal cells intimately associated with the fibrous cyst wall.



Fig. 1. — The lower border of the adrenal cyst is marked by arrow A. The arrows above point out calium in the wall of the cyst, and the arrow to the far left shows calcium in the cyst. The two arrows to the ar right show the outline of the gallbladder, which is pushed to the left side of the spine.

Comment

This paper points out the difficulty in the clinical diagnosis of this entity. The difficulty centers largely from the lack of any specific symptomatology. The most helpful diagnostic aid is preoperative x-ray studies of the abdomen revealing a mass. In one third of the cases of adrenal cyst, there is a rim of calcium in the cyst wall.

No specific underlying endocrine disturbances were noted in this patient as supported in the findings of Gardiner, Bell and Althausen. Other differential possibilities should include: Cyst and tumor of the spleen, pancreas, liver, kidney, and mesentery, as well as empyema of the gallbladder, splenic artery aneurysms, hydatid cyst, urachal cyst, dermoid cyst, and solid adrenal tumors.

Because of the numerous diagnostic possibilities and the chance of bilateral disease, the transabdominal approach for surgical removal was selected. With the benign appearance of the mass, aspiration to reduce its size greatly facilitated the extirpation of this lesion.

The most generally accepted pathological classification of adrenal cyst is as follows: (1) The glandular cysts, (2) parasitic cysts, (3) cystic adenomas, (4) serous (lymphatic) cysts, and (5) pseudocysts. The pathologic diagnosis in this case was hemorrhagic pseudocyst.

Summary

A case of adrenal cyst, emphasizing the difficulty of preoperative diagnosis, x-ray studies as the most helpful diagnostic aid, and surgical excision as the treatment of choice, is reported.

References are available from the authors upon request.

▶ Dr. Ferguson, 2700 Riverside Avenue, Jacksonville 32205

New Advertising Approach

A unique form of pharmaceutical advertising—the combining of medical service information in editorial form with the drug advertisement itself—appears in this issue. Dorsey Laboratories plans to repeat such advertising on a seasonal basis and on a variety of products depending on the response which the ad produces. Comments addressed to Dr. Raymond C. Pogge, Dorsey Laboratories, Lincoln, Nebraska, are solicited by the advertiser.

Management of Anxiety in Internal Medicine with Oxazepam

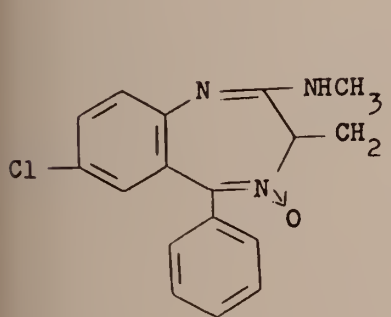
HYMAN MERLIN, M.D.

Oxazepam* is a new antianxiety agent belonging to the benzodiazepine series of compounds, which also includes chlordiazepoxide and diazepam. Preclinical testing in animals indicated it had greater potency than chlordiazepoxide and greater flexibility in dosage, making it safer for extended clinical evaluation.[1] Moreover, laboratory data suggested that at effective therapeutic dosages in humans it may cause less ataxia than either chlordiazepoxide or diazepam.

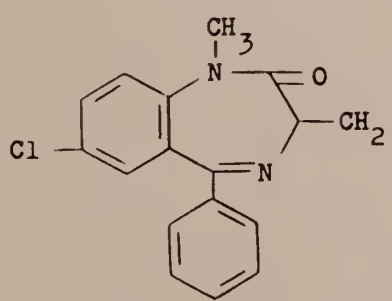
Chemistry and Clinical Pharmacology

Oxazepam is 7-chloro-1, 3-dihydro-3-hydroxy-5-phenyl-2 *H*-1, 4-benzodiazepin-2-one and differs structurally from chlordiazepoxide and diazepam in the peripheral substituents attached to the diazepine ring:

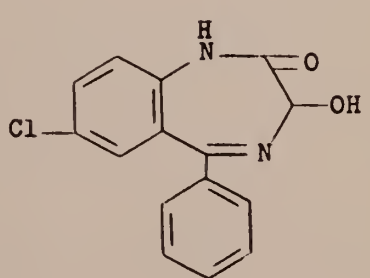
The benzodiazepines are unrelated to any other class of tranquilizing or antianxiety agents, and experience with them indicates they are among the safest psychopharmacological compounds available. Chlordiazepoxide does cause drowsiness, lethargy and some ataxia, notably in the elderly and during the earlier phases of treatment. Avoidance behavior studies in rats show that oxazepam produces less nonspecific depression, motor incoordination and ataxia than either chlordiazepoxide or diazepam at doses that effectively reduce conflict behavior.[2] Electroencephalographic studies in cats show that oxazepam has the general actions characteristic of all central nervous system depressants. In anesthetized dogs, oxazepam causes a slight depression of blood pressure, heart rate, and force of cardiac contrac-



CHLORDIAZEPOXIDE



DIAZEPAM



OXAZEPAM

*Wyeth Laboratories, Philadelphia, Pa.

tion similar to other benzodiazepine derivatives and not of sufficient magnitude to contraindicate clinical use. Except for a lower sedative-ataxic ratio and less muscle relaxant activity, oxazepam appears similar in potency to diazepam and is more potent in all laboratory tests than chlordiazepoxide.[1]

Procedure

Oxazepam has been tested for control of anxiety in 81 patients treated in the private practice of internal medicine. In 55 patients, anxiety was associated with serious underlying or aggravating organic disease: hypertension, cirrhosis, hemiparesis, parkinsonism, blindness, deafness, arthritis, peptic and duodenal ulcer, arteriosclerotic, congestive and rheumatic heart disease, hypotension, hypothyroidism, labyrinthitis, cholelithiasis and cholecystitis, horseshoe kidney, functional bowel disease and irritable colon, asthma, diabetes, cancer, and coronary thrombosis. In 26 patients no organic entity was discernible, but a severe anxiety reaction was present that had resisted previous treatment with sedatives and tranquilizers (chlordiazepoxide, perphenazine, trifluoperazine, chlorpromazine, meprobamate, and phenobarbital) or antidepressants (isocarboxazid, amitriptyline hydrochloride, and tranylcypromine sulfate). The series, though not exclusively a geriatric population, was composed largely of older patients; the youngest were in their twenties, but 51 (63 per cent) were more than 50 years of age and the average age was greater than 50 years (table 1).

Capsules of oxazepam, 10 mg. per capsule, were administered two to four times a day, depending on the age of the patient and the changing severity of the anxiety state, but 36 patients received one capsule three times a day and 44 received one four times a day during the greater portion of their treatment periods. The majority of treatments did not extend beyond eight weeks (table 2). Therapy for the organic disorders, the primary immediate responsibility, was carried out as indicated.

Table 1.— Age and Sex of Patients

Age Range	Number of Women	Number of Men	Totals
20-29	2	2	4
30-39	7	4	11
40-49	6	9	15
50-59	21	8	29
60-69	13	3	16
70-79	4	2	6
TOTALS	53	28	81

Comprehensive records showing the severity of anxiety at the start of treatment and later at frequent in-treatment examinations were kept. In the records, the anxiety (and tension, if also present) was graded on a four point numerical scale, 3 standing for the most severe, 2 for less severe, 1 for moderate, and 0 for none. Before the start of therapy, 74 of the 81 patients had severe, persistent anxiety resulting in marked loss of function (grade 3) and the remainder had anxiety that caused somewhat less discomfort and loss of function (grade 2). As therapy progressed, anxiety either grew worse, remained stationary, or declined through 2 or 1 and perhaps finally reached 0. If anxiety was completely controlled by oxazepam and function was restored, the result of treatment was classified as excellent. If the response was such that only moderate anxiety remained, the result of treatment was considered good. All other results were regarded as unsatisfactory, even though there may have been some control of anxiety (reduction from 3 to 2) or partial restoration of function.

Results of Treatment

The results of treatment were excellent in 50 patients and good in 18 more, for a total of 68 treatments in which anxiety was adequately controlled and functional capacity largely restored (satisfactory responses in 84 per cent of the patients). The medication was of some functional help to an additional six patients, but seven made no progress on continued treatment (table 2).

Such results are impressive if the poor physical status of the patients and the rigid criteria for evaluating their responses are taken into account, especially since functional capacity was greatly restored in 68 and improved in an additional six (partial to complete reduction of disabling discomfort and reestablishment of function in 91 per cent).

Twenty-seven patients were known to have been taking chlordiazepoxide previously with poor or doubtful results. Of these, 21 had a satisfactory

Table 2. — Results of Treatment with Oxazepam

Daily Dosage	Weeks of Treatment	Type of Response Excellent	Good	Slight	None	Totals
	1-4	7	5		2	14
	5-8	3	4	1	2	10
30 mg.	9-12	1		1		2
	13-16	2	3	1	2	8
	17-20	2				2
	1-4	12	1	3	1	17
	5-8	14	3			17
	9-12	6	1			7
40 mg.	13-16		1			1
	17-20					
	21-24	1				1
	25-28	1				1
TOTALS		49	18	6	7	80*

*For convenience in tabulating, one patient who received oxazepam only at bedtime has been excluded. In this case, reduction of anxiety was excellent and occurred in four weeks.

reduction in anxiety and increase in function with oxazepam.

Twenty-five patients included in the anxiety series, along with six excluded because anxiety per se had not been a complaint, were treated for one or more symptoms commonly associated with an anxiety state: depression, irritability, headache, phobic reaction, obsessive-compulsive behavior, impotency, agitation, and insomnia. In depression related to anxiety, seven of nine patients obtained relief. Nine out of 10 patients with insomnia were greatly benefited, although one required adjunctive meprobamate at bedtime. Irritability responded adequately in three out of five instances. As anticipated, the other related symptoms proved less tractable to therapy.

Success of oxazepam therapy seemed more closely related to dosage level employed and to physical status of the patient than to other factors. Nine of the 13 patients who had unsatisfactory relief of anxiety had received the lower dosage of oxazepam (10 mg. three rather than four times a day). Five became drowsy, and in two the dosage was decreased. Whether larger doses might have been more effective is not known.

Five patients who did not respond adequately were hypertensive. A 50 year old woman who had hypertension, diabetes and coronary insufficiency showed initial progress on oxazepam, but the medication appeared to lose effectiveness later on, and she stopped therapy of her own accord at the end of six weeks. A 65 year old man with parkinsonism had many symptoms in addition to anxiety and tension: irritability, insomnia, agitation, and obsessive-compulsive reactions. None of these symptoms were improved at the end of five weeks of therapy, when the drug was discontinued because of marked drowsiness, nausea and headache. The patient with coronary thrombosis died after five weeks of treatment. His severe anxiety reflected justifiable concern with his physical status and was not improved by oxazepam therapy. In two patients who were only slightly improved, therapy was particularly difficult to evaluate, in one, a woman with a menopausal syndrome, because of poor cooperation and in the other, a young woman with hypothyroidism, because of her refusal to take further medication after three weeks.

Side Effects

Oxazepam had only minor side effects. Transient drowsiness was noted in 11 (13 per cent) and was usually correlated with positive antianxiety effects. Severe nausea that persisted in spite of dosage reduction was reported by one patient. The occurrence of nausea associated with drowsiness and headache in the patient with parkinsonism has already been described. No ataxia or other side effects occurred.

Discussion

In the present series, the dosage of oxazepam was restricted to a maximum of 40 mg. daily,

even though preliminary clinical trials pointed to the feasibility of increasing the dosage to as high as 30 mg. four times daily for control of more refractory anxiety; psychotic patients treated for concomitant anxiety and tension have tolerated even greater amounts.[1] By analogy with chlordiazepoxide requirements, which in geriatric or debilitated patients usually do not exceed 5 mg. three or four times daily, it was considered prudent to limit oxazepam administration during this testing period. Since the results show the medication to have practically no toxic potential in the dosage employed, thus confirming the pharmacological and preliminary clinical data, future dosage adjustments can be made more confidently. A more flexible dosage—with the medication prescribed on a more highly individualized basis—would almost certainly bring about a greater number of excellent responses.

Most patients expressed satisfaction with oxazepam, stating that they preferred it to former antianxiety medications and urging that it be dispensed beyond the scope of the present protocol. To the investigator, who has observed the total effects of tranquilizers in many patients over a period of years and has noted a high frequency of sedation and ataxia produced by the otherwise excellent chlordiazepoxide, the superior control of anxiety attainable with oxazepam and the relative freedom from undesirable reactions were decidedly more impressive.

Summary

Oxazepam was administered to 81 patients seen in the routine office practice of internal medicine. Each patient had severe anxiety superimposed on one or more serious organic disorders or constituting part of a profound anxiety-tension state. Oxazepam, a new anxiety agent of the benzodiazepine type, had been reported as more potent than chlordiazepoxide and to cause less frequent, less marked drowsiness and ataxia. It was administered orally in a daily dosage of 30 or 40 mg. and evaluated in terms of reduction of anxiety from visit to visit on a four point numerical scale. Primary therapy for basic organic disease states was carried out as indicated.

Relief of anxiety was excellent in 50 patients and good in 18 more; thus, relief of symptoms and reestablishment of functional capacity were definite and most satisfactory in 84 per cent. In 27 patients who had been treated with chlordiazepoxide with equivocal results, satisfactory relief of symptoms and improvement in function were provided by oxazepam in 21. Depression, irritability, and insomnia responded to oxazepam, but other neurotic symptoms appeared to be less responsive. Several of the therapeutic failures could be explained in terms of low dosage of medication or the poor physical status of the patient. In future trials of the compound the dosage can be more highly individualized and flexible. Based on the present results, an occasional transient drowsiness and a rare nausea can be expected, but ataxia or serious reactions have not occurred.

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Duplication of the Stomach

Report of A Case

MARVIN G. BURDETTE, M.D. and ALDEN B. RYON, M.D.

Duplication of the stomach is a rare condition, there being only about 38 cases reported in the English literature during the past 43 years.[1] One additional case depicting an unusual gastric duplication with a ruptured jejunal ulcer was reported in 1962.[2] Gross[3] reported 68 cases of duplication of the alimentary tract in 1953, in only two of which the duplication arose from the stomach wall.

The case reported is unusual because of the age of the patient (three weeks), and the clinical history suggesting pyloric stenosis.

Report of Case

An infant, born Nov. 30, 1962, was a second child. Spontaneous delivery was normal and the birth weight was 8 pounds, 7½ ounces. On December 4, the child began vomiting and failed to gain weight. Examination at that time revealed a small olive-sized mass in the right side of the epigastrium which was thought to be a prominent pylorus. X-rays, however, revealed a normal pyloric canal with normal mucosal pattern and no definite obstruction (fig. 3). The child was then sent home, given a belladonna preparation (Donnatal 1 cc. four times a day), and did fairly well until seen again on December 21. At that time the baby was vomiting supplemental formula, but was retaining breast feeding.

On physicial examination, Dec. 22, 1963, the mass in the right side of the epigastrium had increased from olive size to a size larger than a golf ball (figs. 1 and 4). The remainder of the examination gave results within normal limits. The white blood cell count was 10,000 per cubic millimeter, with segmented forms 46%, stab forms 2% and lymphocytes 52%. The hemoglobin level was 18.2 Gm., and the CVP was 50. A barium enema study at that time revealed a mass in the right upper quadrant of the abdomen which measured 5 cm. in diameter and displaced the colon downward (fig. 4). Because of the location of the mass, an intravenous pyelogram was obtained on December 24, which revealed normal findings (fig. 2); but the stomach was markedly distended with gas.

The child was operated upon under Vinethene, nitrous oxide and ether anesthesia through a right paramedian muscle-retracting incision. A cystic structure 5 cm. in diameter arising from the pyloric area of the stomach was excised. The outer portion of the mass seemed to be made up of visceral peritoneum and muscularis, but there was no communication between the lumen of the cyst and the lumen of the pylorus. The latter appeared to be completely compressed by the extrinsic mass. The cystic structure contained a clear, thick mucus-like material. The mass was not opened during the dissection until it was being dissected near its junction with the pyloric musculature. At one point the mucosa of the pylorus was opened, inadvertedly and closed with 4-0 chromic catgut. The muscularis and serosa were also closed with catgut, restoring the pylorus to a normal appearance.

The gross and microscopic report of the pathologist was as follows: "Gross Description: The specimen consists of a collapsed cystic structure, measuring approximately 5 x 4 x 3.5 cm. The surface was grayish pink and translucent. The inner lining was smooth and the lumen contained somewhat mucoid glary material. The wall, in focal areas, displayed an almost hyalinized thickening. No papillary structures were observed. A defect was present in the wall of one aspect (accidental opening at operation). Microscopic Description: Sections of the cystic structure revealed a muscular wall which was arranged in fairly well developed circular and longitudinal layers. The mucosa was focally eroded, but in many zones consisted of a tall cuboidal to columnar type of epithelium, which in some zones displayed underlying mucous type glands and resembled fairly closely normal infantile gastric mucosa. There was no evidence of malignant degeneration. Diagnosis: Duplication of stomach, cystic."

Following the operation the infant did well. A Levin tube was kept in the stomach for 24 hours, removed and



Fig. 1. — There is an ill-defined density in the right upper quadrant incident to the palpable mass. Fig. 2. — Excretory urogram is normal. Both kidneys excreted the dye promptly, and there is no displacement or distortion of the upper collecting systems.



Fig. 3. — There is evidence of extrinsic pressure on the antrum of the stomach and duodenum. The pylorus was not obstructed. Fig. 4. — The hepatic flexure and proximal transverse colon are displaced downward by the mass in the right upper quadrant. No intrinsic abnormalities were noted in the colon or terminal ileum.

oral fluids begun, thus discontinuing the intravenous fluids through a cutdown. He had three stools on the second post-operative day. There was no vomiting postoperatively. The child was sent home on the fourth post-operative day.

Follow-up care failed to reveal any other malformations and he was healthy and normal three years after the operation.

Comments

Few cases of duplication of the stomach are reported in the English literature and in only a fraction of these did the duplication originate from the stomach wall. A case is reported in which a three week old infant had signs and symptoms suggesting pyloric stenosis, but who was found to have a cystic duplication at the pylorus.

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Dispensing The Sample

The samples you get from drug companies are intended for one purpose: to be given to patients as a trial. However, if no written prescription accompanies the sample, the transaction looks like the dispensing of a home remedy; or looks as if the patient is being used as a guinea pig. Common sense suggests that the sample should be accompanied by a written prescription for the same item.

It might be best to tell the patient: "This is a sample of a new (or a good old) medicine that has had some fine results. If it is as favorable as I expect it to be, take the prescription to your neighborhood drug store so you can get more of this medicine. If you are disappointed in the results, call me."

This simple procedure will prevent the embarrassment of an otherwise satisfied patient trying to get the drug without a prescription. It will lift the medication into the dignified "prescription" class rather than make it look like a casual free sample. It indicates that the doctor is not going out on a limb, calling it a wonder drug. And it acts as an automatic (if not entirely scientific) check on the effectiveness and safety of a new drug.

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Clinicopathological Conference

A Case of Long-Standing Miliary Infiltrate of the Lungs In a Patient with Paralysis of Vocal Cord

Hervey P. Brittain, M.D.
Resident Pathologist

Wade S. Rizk, M.D. Attending
Radiologist

Max Michael Jr., M.D.,
Discussant

Edward N. Willey, M.D.,
Attending Pathologist

John Derfer, Ph.D., Visiting
Chemist

A 47 year old Negro woman was admitted to the Duval Medical Center on Aug. 22, 1956, for evaluation of an abnormal chest x-ray which was made at the Florida State Board of Health. Her chief complaint on admission was nervousness and rapid heart action.

She had been bothered by spells of rapid heart action for some 15 years. They would come on suddenly and leave just as suddenly. She also had nervous spells which were characterized by shaking of her hands and which had increased since the death of her husband about three months previously. She had lost about 8 to 10 pounds in the last six months. Her past medical history was significant in that she had pleurisy and pneumonia three times in her life. In 1929, she had a "golf ball sized goiter" which was apparently in the midline of her throat and was treated with "shots." Nothing else is known about this condition. She had verified hypertension for 12 years. Menses began at age 13 and ceased at age 37. She had never been pregnant. She was born in Georgia and worked as a farm hand or domestic all her life.

She had moderate shortness of breath during fairly rigorous exertion, but never had asthma and did not wheeze. She complained of some constipation. She denied syphilis, but it is known that she was treated for a positive Wassermann in the Duval County Health Clinic.

On physical examination the blood pressure was 200/105 mm. Hg. The pulse rate was 84 per minute and regular. The temperature was 98.4 F.

Duval Medical Center, Jacksonville, Florida, May 28, 1965

Duval Medical Center

The patient was an 87 pound Negro woman in no acute distress. She spoke with a high-pitched hoarse voice which she said had been present since her thyroid trouble in 1929. The pupils were round and equal and reacted to light. There were grade I to II arteriovenous changes in the fundi. The thyroid gland was unremarkable on palpation. There were no scars in the area. A few scattered rales were heard over both lung bases. The heart was enlarged to the left of the midclavicular line with the point of maximum impulse in the sixth intercostal space. A faint apical systolic murmur was heard. The pulmonary second sound was split normally and the aortic second sound was tambouric in quality. On examination of the abdomen there was a great deal of voluntary rigidity; however, no apparent tenderness was elicited. The spleen and kidneys were not palpable and the liver was not enlarged. The pelvic and rectal examinations were normal. The skin was warm and thin with good turgor. There was no significant adenopathy. The deep tendon reflexes were very active. No Babinski reflex was elicited.

The white blood cell count was 12,800/cmm. with three bands, 70 segmented neutrophils, 24 lymphocytes, one monocyte and two eosinophils. On two occasions the feces were negative for ova and parasites. Urinalysis showed a slight trace of protein, but otherwise was normal. The sedimentation rate was 53 mm. at the end of an hour with a packed cell volume of 36. Total proteins were 9.6 Gm.% with a 5.6 to 4 albumin/globulin ratio. Blood sugar was 70 mg.% and BUN was 12 mg.%. The radioactive iodine uptake was within normal limits. A Regitine test was done with a negative result. The serum calcium was 9.6 mg.%. Skin tests for blastomycosis, coccidioidomycosis and histoplasmosis were all negative. Complement fixation tests for the three fungi were also negative. An old Tuberculin skin test was negative. The patient was subjected to bronchoscopy with normal findings. Washings taken from both main stem bronchi were negative for fungi and acid-fast bacilli. She had a scalene fat pad removed with a pathologic diagnosis of "sinus hyperplasia of lymph node." A bone marrow aspirate was normal. An electrocardiogram showed T-waves to be flattened throughout, but was otherwise normal.

The patient withstood these procedures without complaint. She was afebrile during the entire course. She was digitalized and placed on diuretics and appeared to be symptomatically better. The appearance of her chest film, however, did not improve. This treatment was later abandoned without ill effect. She was discharged. No diagnosis was made.

The patient continued to be seen in the Outpatient Department periodically. She continued to have elevated blood pressure and was treated with such drugs as Rauwolfia, reserpine and chlorothiazides. The lung disease seemed to progress very slowly. The patient became a little more short of breath on exertion. In August 1962, she was readmitted to the hospital. A scalene fat pad was removed, but no nodes were found in it. Later in 1962, the patient underwent direct laryngoscopy to determine the reason for her hoarseness. It was found that the left vocal cord was paralyzed. It was thought, however, that this

abnormality probably dated back to 1929. She was again admitted to the hospital in October 1963. Essentially the same history was obtained. She had no pedal edema and no paroxysmal nocturnal dyspnea. She had no orthopnea. She had had no cough nor hemoptysis. She complained of occasional diarrhea but no melena. At this time the hemoglobin was 13 Gm.%, white blood cell count 6,800/cmm. with 55 segmented neutrophils, 33 lymphocytes, eight monocytes and four eosinophils. There was 1 plus albuminuria with two to six white cells and no red cells. Several serum calcium determinations were done during this time. These were normal. The highest was 10.3 mg.%. On Sept. 23, 1963, the following respiratory function studies were obtained.

Maximum breathing capacity 57L/min, 98% predicted. (15 sec.). Maximum breathing capacity 58L/min, 100% predicted. (15 sec.)

Vital capacity:

	1 sec.	2 sec.	3 sec.	Total	Predicted Total
Vol. in ml.	1188	1404	1512	1512	2445
% Total	78%	93%	100%	100%	62%

There was no significant change with Isuprel. Since 1956, 39 cultures had been done for mycobacteria and 24 cultures for fungi, all of which were negative. Many lupus erythematosus cell preparations were negative. A serum electrophoresis showed a reversed albumin/globulin ratio due to increased beta and gamma globulins. A lung biopsy was done during this last hospital admission. The patient was given a trial course of prednisone with no apparent improvement. She was again discharged to be followed in the Outpatient Department. She was last seen on Jan. 7, 1965. At that time she had few specific complaints.

She was brought to the emergency room on March 8, 1965, dead on arrival. An autopsy was performed.

Hervey P. Brittain, M.D.
Resident Pathologist

X-ray films taken on Aug. 23, 1962, Oct. 27, 1963, and Jan. 1, 1964 reveal a disseminated micronodular infiltration throughout both lungs sparing only the apices. The first film of this series shows an acinar pattern with wide distribution. The later films show progression of the process with confluence and linear streakings indicative of thickening of the interlobular septa. Also present in the two later films is honeycomb shadowing due to microcyst formation. Note also the progressive enlargement of the right parahilar shadow due to conglomeration of the micronodular shadows with fibrosis (fig. 1). The costophrenic sulci are relatively clear. Our only previous film now is the original 75 mm. film from the State Board of Health made in 1956, which shows the same pattern of disease at an earlier stage. The intervening films between 1956 and 1962 were lost in the "great record room flood of 1961," but even without these intervening films it appears that the disease was a slowly and inexorably progressive one.

Wade S. Rizk, M.D.
Attending Radiologist



Fig. 1. — Chest x-ray. Diffuse nodular fibrosis of both lungs.

This was a 56 year old Negro woman who had a slowly progressive diffuse infiltrative relatively asymptomatic disease of the lungs with only minimal impairment of respiratory function. She had hypertension, a past history of a goiter of unknown type and description, and a paralysis of the left vocal cord. She had elevated globulins, a mild eosinophilia and an increased sedimentation rate. All skin tests were negative. Her death was sudden. Several available chest x-rays indicate that there was very slow progression of the diffuse infiltrative pulmonary disease over a period of nine years.

In discussing the problem of diffuse infiltrative pulmonary disease I wish to direct your attention to this table which lists over 100 possible diseases to be considered (table 1).[1]

Many infections may produce a radiographic picture such as this patient had. The two types of infective disease that must be considered most strongly are tuberculosis and fungal infections. Tuberculosis is highly unlikely because of the duration of the clinical course and the failure to isolate the organism in 39 cultures. There is, however, a chronic nodular slowly progressive form of tuberculosis in which it is difficult to isolate the organism. In this patient the tuberculin was negative and the sputum was negative, as is usually the case in such chronic nodular tuberculosis. This would be exceedingly unlikely in view of the long duration. Similarly, fungal infections of which we have no evidence are a possibility although very unlikely because of the long duration. Collagen diseases may produce such lesions

Table 1. — Causes of Miliary Disease of the Lungs

Bacterial Diseases	
Miliary Tuberculosis	Brucellosis
Diffuse Indolent Pulmonary Tuberculosis	Tularemia
Staphylococcal Infection	Salmonella Infection
Streptococcal Infection	Shigella Infection
Friedländer's Pneumonia	Whooping Cough
Fungus Diseases	
Histoplasmosis	Cryptococcosis
Coccidioidomycosis	Moniliasis
Blastomycosis	Geotrichosis
Actinomycosis	Nocardiosis
Aspergillosis	Maple Bark Disease
Viral	
Chickenpox	Influenza
Measles	Primary Atypical Pneumonia
Psittacosis	Hemorrhagic Fever
Rickettsial	
Q Fever	Rocky Mountain Spotted Fever
Spirochetal	
Syphilis	
Parasitic	
Schistosomiasis	Toxoplasmosis
Disorders due to Inhalation of Foreign Materials	
Bagassosis	Silver Pneumoconiosis
Silicosis	Platinum Pneumoconiosis
Shaver's Disease	Osmium Pneumoconiosis
Diatomaceous Earth Disease	Vanadium Pneumoconiosis
Asbestosis	Manganese Pneumoconiosis
Talc Pneumoconiosis	Stannosis
Berylliosis	Byssinosis
Anthracosis	Soap Dust Pneumoconiosis
Siderosis (Arc Welder's Disease)	Iodized Oil in Lungs After Bronchography
Barium Pneumoconiosis	

Disorders Due to Inhalation of Vapors

Phosgene	Chlorine
Nitrogen Dioxide (Silo Filler's Disease)	Picric Acid
Nitrogen Oxide (Electric Welding)	Ammonia
Mustard Gas	Sulfur Dioxide
Lewisite	Bromine
Conflagration Pneumonia	Hydrogen Fluoride
Carbon Tetrachloride	Nitric Acid
Acetylene Gas	Hydrochloric Acid

Diffuse Focal Aspiration Pneumonia

Lipoid Pneumonia	After Resuscitation from Drowning
After Hemoptysis	Associated with Unconsciousness

Allergic Diseases

Löffler's Syndrome	Asthma
Tropical Eosinophilia	Hexamethonium and Hydralazine

The Collagen Diseases

Lupus Erythematosis	Wegner's Granulomatosis
Scleroderma	Erythema Nodosum
Periarteritis Nodosa	Dermatomyositis

Neoplastic Diseases

Leukemia	Alveolar Cell Carcinoma
Hodgkin's Disease	Blood-Borne Metastasis
Pulmonary Adenomatosis	Lymphangitic Carcinomatosis

Miscellaneous Disorders of Uncertain Etiology

Sarcoidosis	Infectious Mononucleosis
Diffuse Bronchiolitis	Letterer-Siwe Disease
Hamman-Rich Syndrome	Niemann-Pick Disease
Diffuse Nonspecific Pulmonary Fibrosis	Hand-Schüller-Christian Disease
Muscular Cirrhosis of the Lung	Sickle Cell Disease
Cystic Fibrosis of the Pancreas With Associated Pulmonary Fibrosis and Infection	Pulmonary Alveolar Microlithiasis
	Amyloidosis
	Tuberous Sclerosis
	Interstitial Plasma Cell Pneumonitis (Pneumocystis Carinii)
Congenital Cystic Disease With Pulmonary Fibrosis	Eosinophilic Granuloma
Mycosis Fungoides	

in the lungs, but there are no extrapulmonary manifestations which would lead one to such a diagnosis. Wegner's granulomatosis can be responsible for a pulmonary picture such as seen in this patient; however, one would expect other manifestations such as lesions in the paranasal sinuses or the kidney, none of which are present in this patient. Of the neoplastic diseases, pulmonary adenomatosis or alveolar cell carcinoma would be most likely to produce a diffuse infiltrative pattern such as was seen in this patient. Again, the duration of at least nine years has caused me to rule out this group of diseases.

There are a whole host of diseases which, for lack of knowledge, are called diseases of unknown etiology. In a Negro living in Florida the diagnosis of sarcoidosis is always attractive when there is a picture as we now see in the lungs of this patient. In a patient with sarcoidosis for nine years there should be either greater progression with accompanying fibrosis or regression of the lesions. Sarcoidosis cannot be ruled out, but is unlikely. The clinical course is not typical of alveolar proteinosis although a number of reports indicate that some of these cases are relatively benign and heal without leaving residual lesions. The Hamman-Rich syndrome is another disease capable of producing diffuse infiltrative changes; however, gas diffusion impairment and much more severe alteration of pulmonary function would be

expected in a patient having had diffuse idiopathic pulmonary fibrosis for nine years. Pulmonary hemosiderosis is usually accompanied by anemia and recurrent bouts of hemoptysis. We have recently seen several patients with diffuse pulmonary amyloidosis whose chest x-rays looked somewhat like the x-rays of this patient; however, the underlying disease, multiple myeloma, should have become obvious in nine years. Diffuse pulmonary infiltration caused by inhalants should also be mentioned. Many such forms of diffuse infiltrative disease result from occupational exposure and our patient has no such history. In order to make a diagnosis of pulmonary disease due to an inhalant one is ordinarily dependent entirely upon the history unless inhaled material can be found in the sputum.

In general, the diagnosis of the cause of a diffuse infiltrative pulmonary disease is made in this way:

Step 1. The history and the epidemiology give clues. For example, exposure to hair-spray or an occupational exposure is very helpful.

Step. 2. Certain clues are obtained from x-rays. For example, if there are large bilateral hilar nodes, one thinks strongly of sarcoidosis. The presence of calcification makes one think of histoplasmosis. The presence of fibrosis further can be of some aid, but in general it is unusual to be able to make a diagnosis from the x-ray alone.

Step 3. Extrapulmonary manifestations are of immeasurable help. For example, the eye lesions of sarcoidosis, the lesions in the paranasal sinus or kidneys in Wegner's granulomatosis are valuable clues. Recognition and biopsy of such extrapulmonary lesions is often diagnostic.

Step 4. Lung biopsy or occasionally biopsy of a scalene node is usually necessary to secure a diagnosis in a patient such as we are now discussing who has pulmonary disease alone.

Now, let us turn to pulmonary eosinophilic granulomatosis, which is what I think this patient had, and review briefly some of the clinical features of this disease.[2] The symptoms are astonishingly mild with slight coughing. The lesions may tend to regress although I have seen them persist for a number of years as they have in this patient. The pulmonary lesions are diffuse nodular infiltrates which may be discrete or may be confluent. Occasionally a diffuse reticular fibrotic pattern is superimposed. As the disease progresses, small cystic areas occur throughout the lungs. The lesions may be unilateral, but are usually bilateral. There are nonpulmonary manifestations of the disease in less than one fourth of cases. In some patients lesions may heal without leaving any trace by x-ray in lungs, but they usually are progressive and produce cystic areas of varying sizes so as to produce a honeycomb lung. All of these features are consistent with the findings in this case.

As in all conference cases, red herrings must be recognized and rejected. I have considered the goiter of undetermined type with an undetermined treatment, the hypertension, the paralysis of the vocal cord and the sudden death as such misleading bits of information in this case. I am inclined to think that the sudden death, for example, may not be related to the primary pulmonary disease at all.

In summary, I believe that the most likely diagnosis is eosinophilic granuloma of the lungs.

Max Michael Jr., M.D.
Discussant

External examination of the body was normal except for scalene biopsy scars. The left laryngeal nerve was not dissected, and the thyroid was normal. The myocardium in the wall of the left ventricle was hypertrophic. The left lung weighed 900 Gm. and the right 890 Gm. There was marked fibrosis and there were irregular areas of apparent caseation up to 3 to 4 mm. in diameter. The bronchial lymph nodes were expanded and had the same type granulomatous lesion as the lungs. In the inferior lobes bilaterally there was irregular fibrosis and there were irregular, firm, white and yellowish areas which formed an irregular network throughout the pulmonary parenchyma. The cut surface of the lung was greasy. The sigmoid colon had large numbers of diverticula which were filled with hard fecal material. The gross examination was otherwise unremarkable.

Microscopic examination of the lung showed extreme, chronic, fibrotic lipoid pneumonia (fig. 2), also small areas of caseous necrosis and

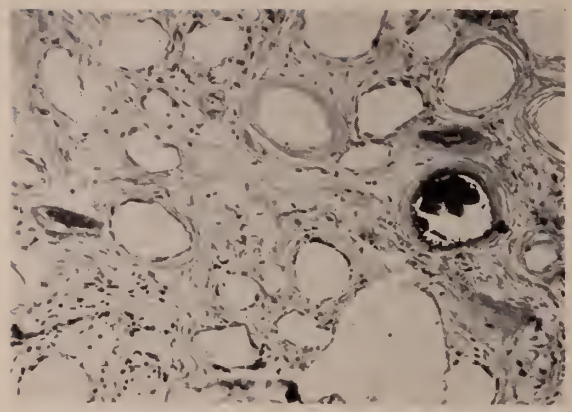


Fig. 2. — 100x photomicrograph of lung. Note fat filled vacuoles, interstitial fibrosis and focus of calcification.

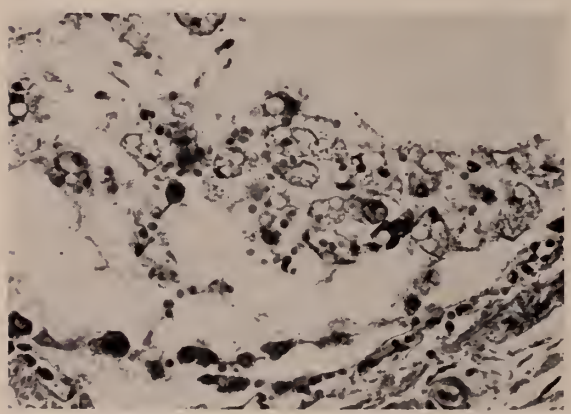


Fig. 3. — 250x photomicrograph of lung. Fat vacuoles in macrophages.

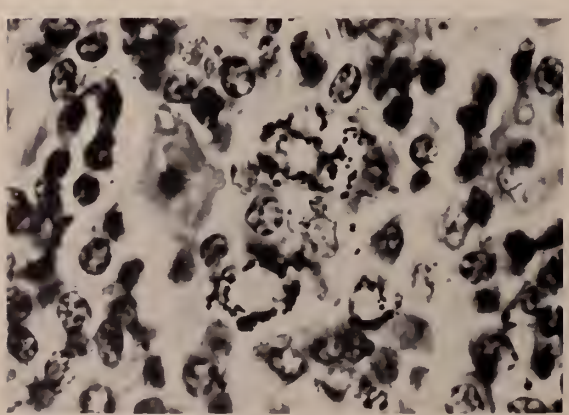


Fig. 4. — 1000x photomicrograph of lymph node showing lipil vacuoles associated with anthracotic pigment.

an occasional small area of calcification. The alveoli contained many vacuolated macrophages (fig. 3). Fat stains showed these vacuoles to be filled with Oil Red O positive material. The bronchial lymph nodes were fibrotic and had numerous macrophages loaded with Oil Red O positive material. There was no evidence of sarcoidosis or tuberculosis in the sections. Acid-fast, periodic acid Schiff, and silver stains of the lungs showed no organisms and cultures of the lungs were negative for mycobacteria and fungi. The thyroid was normal. The lung biopsy, obtained in 1963, was reviewed. It had the same fibrosis and fat cell vacuoles as the autopsy material, although the diagnosis was not made at the time. The lymph node biopsy taken in 1956 was interesting in retrospect (fig. 4). The sections showed macrophages in the scalene lymph nodes which contained both anthracotic pigment and fat vacuoles. These macrophages were similar to the ones seen in the lung and lymph nodes. In this case the possibility for such a diagnosis existed in the early biopsy material although it was not made.

Following discovery of oil in the lung, we called the patient's daughter who told us that the patient was a health faddist and "took mineral oil mixed with honey and lemon juice often—usually several times a week."

This patient's history is fairly typical for a case of mineral oil aspiration pneumonia. She had few symptoms except for some slowly progressive dyspnea. The course was not acute as is often seen in kerosene, gasoline or codliver oil aspiration pneumonia. Sodeman[3] pointed out that mineral oil does not produce a pronounced cough reflex. In this patient the cough reflex may have been even less active than normal in view of the long history of a paralyzed left vocal cord. Medicinal oils in general can produce a pneumonia which can mimic many other pulmonary diseases[4,5] and should be considered in any pneumonia of unknown cause, especially if it is persistent or "chronic." Mineral oil is said to cause expiratory obstruction[6] though the expiratory time in this patient was normal. Her maximum breathing capacity was not greatly impaired; however, her vital capacity was significantly diminished. McDonald and Hodgson[7] reported that necrosis of the lung occurs in some patients with mineral oil aspiration, and Pinkerton[8] thought that this was due to free fatty acids. Our patient had a gross

and microscopic picture of "caseation" which is compatible with their description of "necrosis." Patients with lipoid pneumonia may be asymptomatic until the disease is sufficiently widespread to cause dyspnea by destruction of lung parenchyma.

To prove that the oil in the patient's lung was indeed mineral oil, we sequentially extracted macerated lung with ether and chloroform. A small amount of lung tissue gave us a surprisingly large amount of oil. Through the kind assistance of Dr. John Derfer and Dr. Harry Hunt of the Organic Chemical Division of The Glidden Company, we obtained infrared spectra on the oily lung extract and an ether extract of mineral oil, honey and lemon juice mixture as well as of mineral oil alone.

Edward N. Willey, M.D.
Attending Pathologist:

In order to understand infrared spectroscopy one must understand the molecular structure of a compound to be examined. Each molecule has atoms joined with one another by characteristic bonds. One may visualize this arrangement as

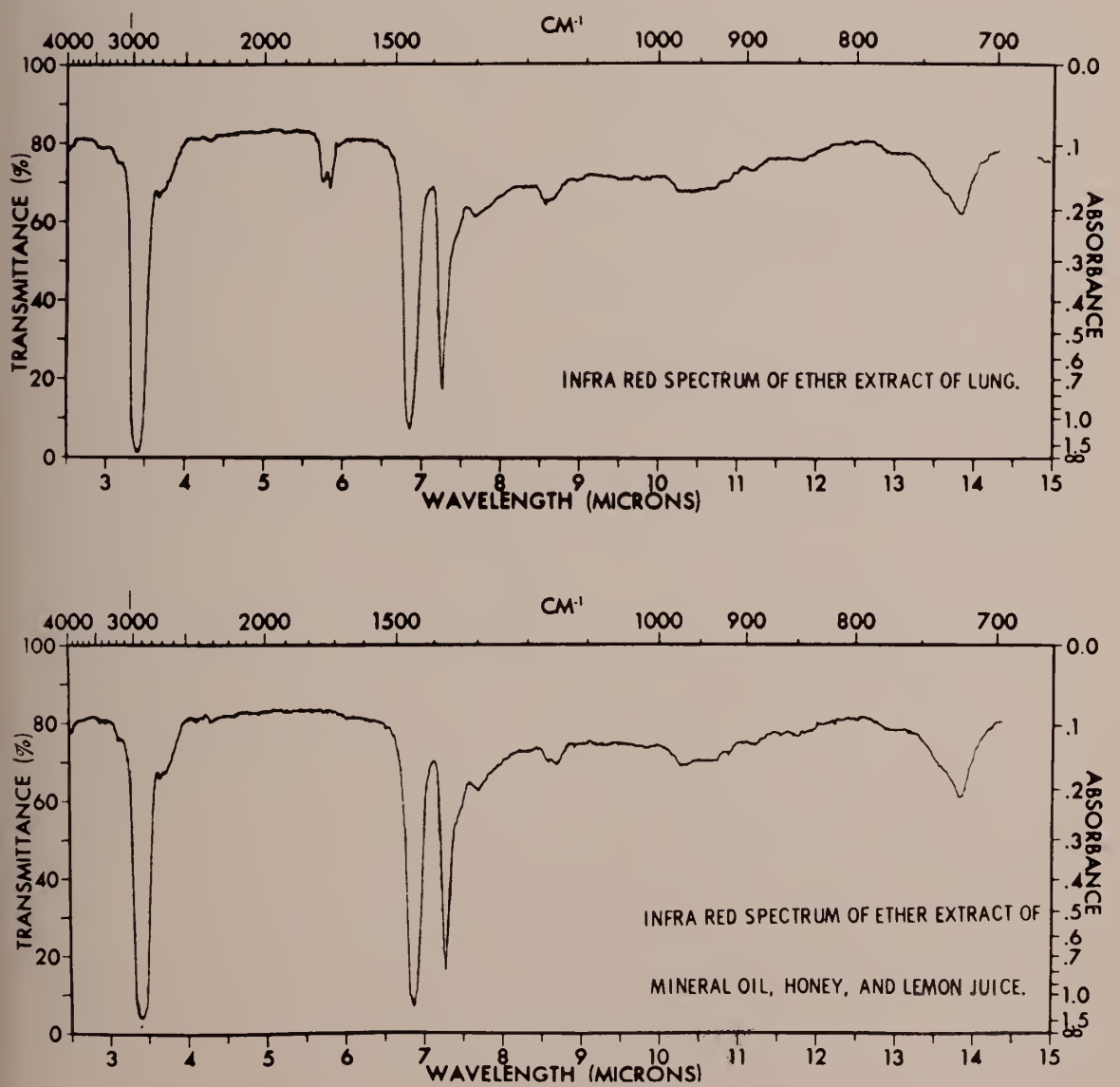


Fig. 5. — Comparision of infrared spectra.

similar to balls of various sizes and weights joined together by various springs. When a molecule is excited by a ray of a given wave length, each bond has a characteristic resonance. In the same manner our mechanical model would have a characteristic resonance of each spring if the ball and spring model were struck a blow. When a molecule is successively exposed to waves of progressively varying length, the resonance of each bond will absorb waves of some lengths but not others. In this way each compound has a characteristic spectral pattern as characteristic of the compound as fingerprints are for a person. In comparing the spectral pattern of the lung extract with the spectral pattern of mineral oil we are struck with the nearly complete identity which demonstrates the presence of mineral oil within the lung (fig. 5). In fact the extract is almost entirely mineral oil with only a slight trace impurity which has not been identified. Whatever this impurity is, it is not present in the extract of mineral oil, honey and lemon juice.

Final clinicopathologic diagnoses:

(1) Mineral oil aspiration pneumonia.

(2) Hypertensive cardiovascular disease.

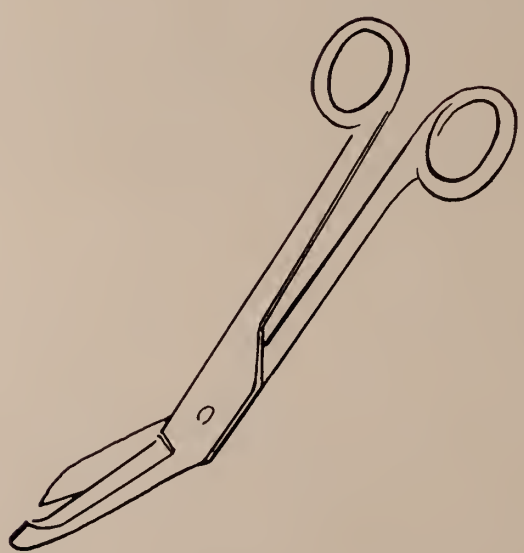
(3) Diverticulosis of sigmoid colon.

JOHN DERFER, Ph.D.
VISITING CHEMIST

References are available from the authors upon request

The authors wish to thank Bryant English, B.P.A., for producing the photographs

▶ Dr. Brittain, Duval Medical Center, Jacksonville 32206



Scopolamine-Induced Acute Brain Syndrome

BURTON J. GOLDSTEIN, M.D.

In recent years nonprescription sleeping medication and sedatives have become available to the public with few or no restrictions. The majority of these preparations contain a combination of drugs, usually an antihistamine with a "sedative," most often scopolamine. The case presented demonstrates the importance of considering scopolamine as an etiological agent in patients with symptoms of an acute brain syndrome (toxic psychosis).

Report of Case

Recently, a 19 year old Caucasian male was brought to the emergency room of the Jackson Memorial Hospital. The youth had been found in bed by his parents after they were aroused by a loud conversation in his bedroom. They described their son as carrying on a loud and incoherent conversation with persons he apparently believed to be in his bedroom. He would laugh and giggle inappropriately while going through "agonizing contortions." At other times he was "picking things off his body." Upon his admission to the emergency room the vital signs were: blood pressure 120/80 mm. Hg, pulse rate 124, respirations 28. Physical examination was normal except for dryness of the skin and parching of the mouth. Neurological examination revealed the patient to be ataxic and the pupils were fully dilated and unresponsive both to light and to accommodation.

The mental status examination revealed a well developed youth who was extremely restless, hyperactive and confused. Throughout the examination he was performing a constant type of plucking movement of the fingers as though he were removing bits of lint from his clothing. Auditory and visual hallucinations appeared to be present and were apparently frightening. He described vividly colored "insects" as trying to harm him. His affect was labile; at times he smiled and giggled while at other times he cried out and withdrew as in fear. He was disoriented in all spheres and his memory, intellectual functions, ability to perform tests of abstraction, and judgment were grossly impaired.

No history could be elicited from the patient and his parents were unable to give any background information except that the patient was in good health until they found him earlier in his room during the day. There was no history of drug ingestion, alcoholic intake, or sniffing of glue. The only positive information received was that the patient enlisted in the military service three weeks previously because he was unable to find work, and was to leave for the service in the near future. In the interval between the time he enlisted and his admission to the hospital he had found a job and decided he did not want to enter the service.

Laboratory Studies: The spinal fluid was clear and colorless with an opening pressure of 130 mm. and a closing pressure of 90 mm. No cells were noted. Protein was reported as 38 mg.%. The complete blood count, urinalysis, VDRL and x-rays were within normal limits.

Course in the Hospital: Within 24 hours the symptoms subsided, and the patient was alert and cooperative. He admitted taking 10 Sominex capsules (each capsule contains scopolamine aminoxide hydrochloride 0.25 mg., methapyrilene hydrochloride 25 mg., salicylamide 200 mg.). He reported that the previous evening he ingested the sleeping medicine in an effort to avoid entering the service. Forty-eight hours later all symptoms noted on admission had disappeared.

Psychological examination, accomplished on the third hospital day, revealed no evidence of psychotic processes.

Discussion

Scopolamine is a member of the belladonna family. In therapeutic doses it produces drowsiness, mild euphoria, amnesia and a dreamless sleep. In larger doses the drug serves as a cerebral stimulant followed by a clouding of the sensorium. Disorientation, confusion, hallucinations, confabulations, restlessness, hyperactivity, delirium, and the typical plucking movements described in this patient are often observed. Idiosyncratic reactions, which mimic the clinical picture of an overdose, are seen more often with scopolamine than any other drug of the belladonna family. The toxic psychosis induced by scopolamine usually lasts several hours, but may persist for days. The symptoms occurring in scopolamine intoxica-

Chief, Division of Research, Department of Psychiatry, University of Miami School of Medicine.

tion are numerous and often include, in addition to the mental picture described, dry skin, visual changes (photophobia, blurring of vision, fixed and dilated pupils), urinary urgency with difficulty in micturition, urinary retention, constipation and skin rash.[1-5]

The physiological response to scopolamine is due to the parasympatholytic effect of this drug. The drug acts indirectly upon the effector cells innervated by cholinergic nerves. Here it interferes with the action of acetylcholine and the result is a depression in the cholinergic activity and the site of central action is most likely the midbrain.

The number of fatalities attributed to scopolamine are few, but the morbidity and seriousness of the untoward effects are great. One of the most potential dangers of an overdose of scopolamine lies in its effect of increasing intraocular tension. This is especially dangerous in older patients or those patients with borderline glaucoma in whom a sudden elevation of intraocular tension may precipitate acute glaucoma, which may result in blindness. In therapeutic doses scopolamine usually acts as a cerebral depressant and the patient feels drowsy and apathetic; a dreamless sleep ensues which lasts for several hours. Overdoses, usually result in a state of cerebral excitement, disorientation, hallucinations, and all the symptoms of an acute toxic psychosis.

The case presented is typical of an acute brain syndrome associated with scopolamine intoxication. An acute organic brain syndrome, characterized by impairment of orientation, memory, intellectual functions, judgment, and lability of affect, is a basic mental condition characteristic of diffuse impairment of brain tissue function from any cause. The additional finding of pupillary dilation which nonresponsiveness to light or accommodation and physiological findings which are parasympatholitic in nature must make the examiner consider the possibility of an overdose or idiosyncratic reaction due to a drug of the belladonna family. n addition to the physiological and mental changes noted, ones' index of suspicion should be enhanced by the knowledge that many preparations used as "sedatives and hypnotics" contain scopolamine and are not restricted to the physician's prescription, but can be purchased with ease.

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Dr. Goldstein, University of Miami, Jackson Memorial Hospital, Miami 33136

President's Page



A Method of Providing Adequate Tax-Supported Medical Assistance For the Needy in Florida

The following resolution was approved by the Board of Governors for presentation to the House of Delegates at the annual meeting of the Florida Medical Association in May 1966:

Whereas, P. L. 89-97 requires all state welfare medical assistance programs eligible for federal participation in costs to provide by the end of 1969 five basic services equal in quality and availability to all welfare recipients and the needy sick (including the services of physicians in the home, office or hospital);

Beginning 1 July 1966, the state of Florida will buy Voluntary Supplementary Medical Insurance for Aged Welfare Recipients under the provisions of Title XVI Social Security Law;

Payment of the deductible (initial $50 costs annually) and 20% coinsurance is not provided by the state plan and cannot be reasonably related to the Aged welfare recipients income;

Equal medical services for the Blind and Disabled welfare recipients under Title XVI are not provided in the state plan;

The state medical assistance plan within the next three years must provide those medical services for the approximately 80,000 Aged, 20,000 Blind and Disabled and 200,000 welfare recipients in the category of Families with Dependent Children plus an indefinite number of needy sick in those categories just above income eligibility for cash subsistence grants;

Blue Shield has been designated the insurance carrier in Florida for Voluntary Supplemental Medical Insurance under the provisions of Title XVIII B, P.L. 89-97; therefore be it

RESOLVED, That the Florida Medical Association:

(1) Approve and actively support the provision of medical services to welfare recipients through agreement with the insurance carrier (Blue Shield) under the provisions of P.L. 89-97;

(2) Encourage the state of Florida to provide required medical services for welfare recipients through the insurance carrier for Voluntary Supplemental Medical Insurance, and, beginning 1 July 1966, insure payment of the deductible and co-insurance for VSMI for the Aged and equal physician services for the Blind and Disabled welfare recipients;

(3) Authorize the Board of Governors through the Florida Medical Foundation to:

(a) Negotiate with the insurance carrier for the provision of physician services to eligible welfare recipients within a reasonable insurance premium,

(b) Permit partial initial payment of fees to participating physicians for services rendered and holding the remainder of the fee in reserve for pro rata distribution at the end of each contract year, and

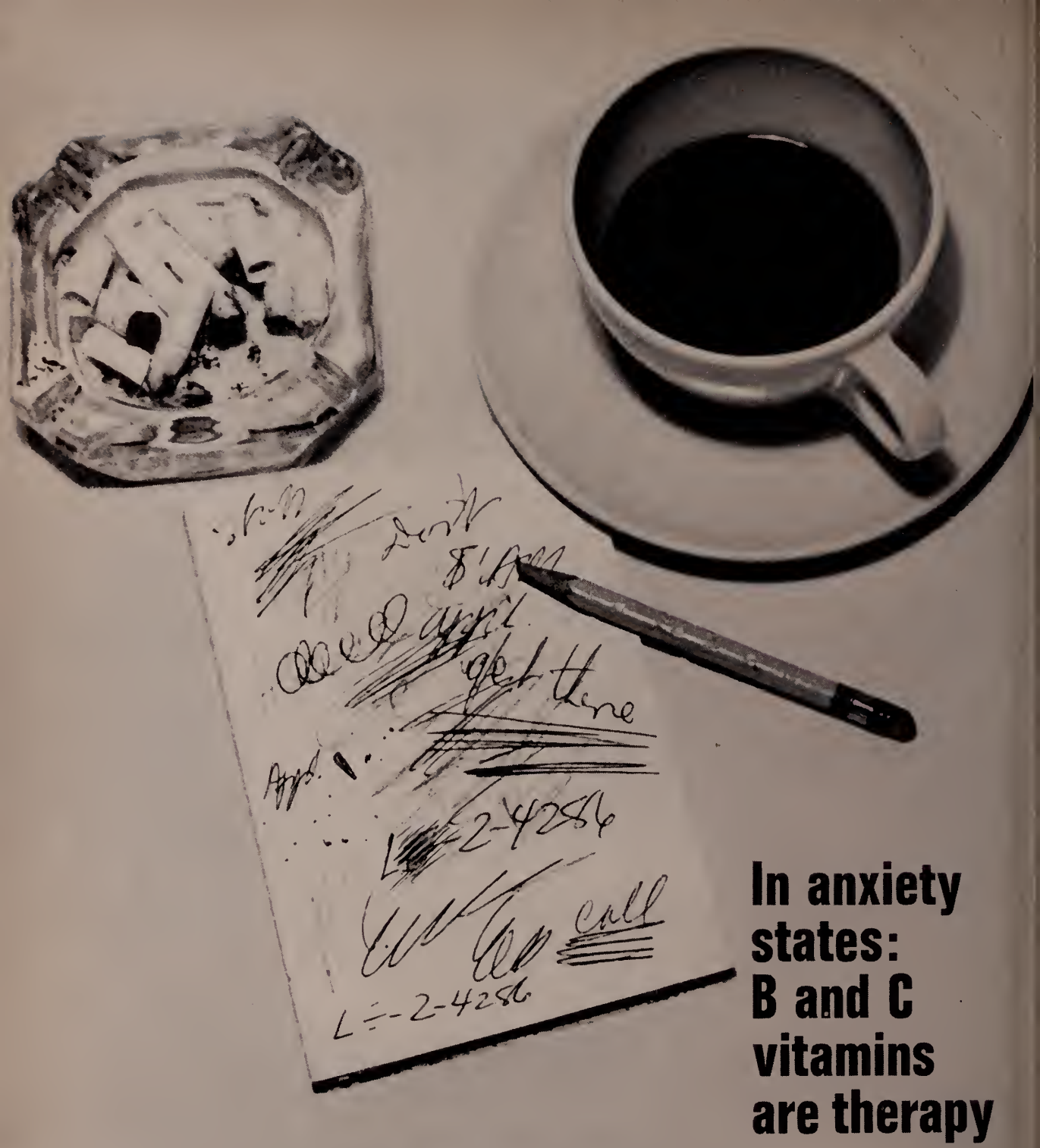
(c) Deduct from the reserve, sums for expenses and other expenditures approved by the Board of Governors.

Provision of adequate medical care for welfare recipients and the needy sick is required by Title XIX of P. L. 89-97. The positive action recommended by this resolution will provide the medical profession with opportunity for control and supervision of the program.

Lacking this action, there will be no alternative to state or federal agency administration of the medical care program by restrictive regulations.

Implementation of Title XIX is a prerequisite to limitation of Social Security tax-supported health care under the provisions of Title XVIII A.

H. Phillip Hampton



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this issue: partners in misery

Partners in misery: common cold and duodenal ulcer*



A century or two ago our forefathers believed that the common cold was caused by an excess of evil humors. Today we regard these baleful humors as a result of the cold rather than its cause. Only in the last ten years have some of the offending viruses been cultivated, and we now know many others can be transmitted to human volunteers although they cannot yet be grown in the laboratory. Various body defenses react to infection by a virus, and in the respiratory tract the lung is protected by the phagocytic properties of the pulmonary alveolar macrophage.[1]

Because of the brief history and large proportion of unidentified viruses, effective prophylactic vaccines have not yet appeared. A universal antiviral agent seems even more remote. Meanwhile, these viruses continue to produce epidemics of upper respiratory infection at seasonal intervals, particularly in spring, fall and winter, during which they propagate and distribute progeny indiscriminately. As a result, they are responsible for significant work loss. Since the immunity afforded is temporary, recurrent infections are common.

This recurrent morbidity in spring and fall is shared by duodenal ulcer, itself a cause of significant loss in wages and medical expense. Thirty years ago Emery and Monroe reported 1,279 recurrences of peptic ulcer of which 13 per cent could be attributed to upper respiratory infection, thus confirming a long-held clinical impression.[2] While the inflammation, congestion and secretion of the mucosa of the nasopharynx in the common cold, and the hyperemia and hypersecretion of the gastric mucosa during acute exacerbation of a duodenal ulcer may not be directly linked, it is probable that the miseries of the infection are reflected in the pain of the ulcer. The following case history illustrates this point.

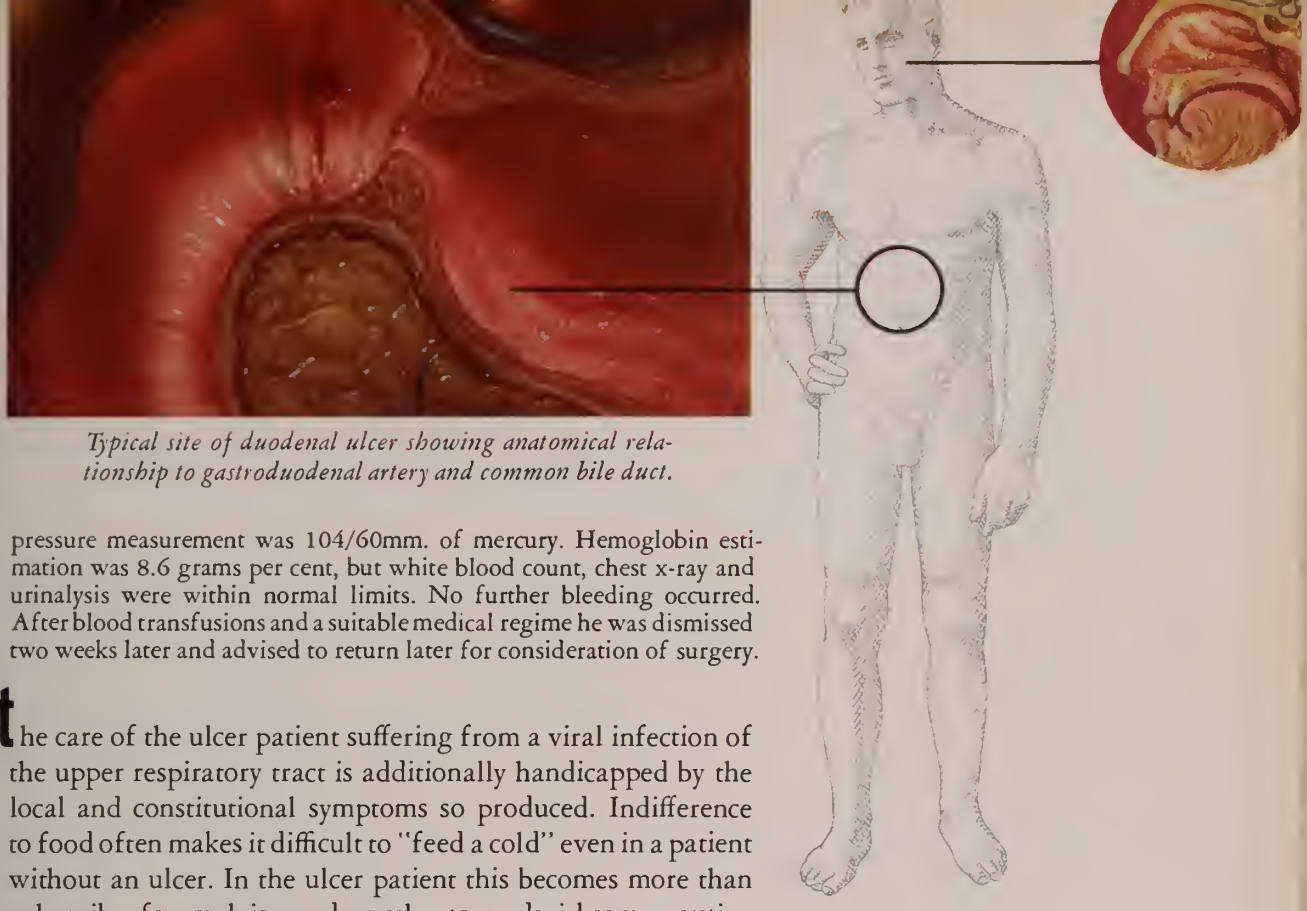
Case report A 48 year old white male executive, suffering from hematemesis and melena for 12 hours was admitted to hospital on April 8, 1965. He gave a history of duodenal ulcer proved by x-ray studies 23 years previously. In the intervening years he suffered from typical epigastric pain occurring two hours postprandially, usually for two or three weeks each spring and fall. A hospital admission two years earlier had followed hematemesis of moderate amount.

The present admission was preceded by a recurrence of pain during a period of unusual business pressure. In addition he caught a cold one week before his entry to hospital and his already irregular eating habits were made more so by loss of taste and appetite, blocked nose and general malaise. During the final 36 hours he used aspirin to relieve his cold, taking 2 or 3 tablets with a glass of water on 6 or 7 occasions. Before retiring he drank a glass of hot toddy.

He awakened about 1 a.m. and vomited dark red blood and recently ingested food mixed with whisky. Melena followed and he was transferred to hospital. On admission he was pale, cold and sweating. Apart from epigastric tenderness and black stool on the examining finger after rectal examination, his general physical examination was not remarkable. Temperature was normal, pulse was thin and thready with a rate of 114 beats per minute, and blood



The commonly found "clover-leaf" roentgenographic abnormality of chronic duodenal ulcer due to spastic contractions and scarring.



Typical site of duodenal ulcer showing anatomical relationship to gastroduodenal artery and common bile duct.

pressure measurement was 104/60mm. of mercury. Hemoglobin estimation was 8.6 grams per cent, but white blood count, chest x-ray and urinalysis were within normal limits. No further bleeding occurred. After blood transfusions and a suitable medical regime he was dismissed two weeks later and advised to return later for consideration of surgery.

The care of the ulcer patient suffering from a viral infection of the upper respiratory tract is additionally handicapped by the local and constitutional symptoms so produced. Indifference to food often makes it difficult to "feed a cold" even in a patient without an ulcer. In the ulcer patient this becomes more than a homily, for malaise and apathy towards irksome routine produce a lack of interest in adhering to an ulcer program and result in its eventual failure if these symptoms are not relieved. The absence of curative treatment for these viral infections has spawned many a strange therapeutic offspring and some of the more generally accepted remedies contain a special risk for the ulcer patient.

To the gastric physiologist, the shot heard around the world was not fired at Concord but was discharged through the stomach of Alexis St. Martin. The worthy voyageur had a more than modest thirst and on several occasions William Beaumont observed through the resulting fistula the changes of gastritis which followed an immoderate ingestion of alcohol.[3] It is now well known that alcohol stimulates the production of gastric juice and the patient with an ulcer, even in remission, should not drink alcohol without first taking food, milk or antacid. The use of various alcoholic remedies for the common cold is to be strongly discouraged in this type of patient. Factors already present can produce an acute exacerbation of ulcer symptoms without the added stimulus of alcohol.

Headache and facial pain, sore throat and generalized aching are subjective discomforts of viral infections of the upper respiratory tract or their complications. Relief from them is usually sought in the family medicine cabinet, and of all the medications habitually stored there, salicylates are the most frequently used. Oral ingestion of salicylates has produced



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substernal pyrosis and sometimes epigastric pain in susceptible individuals. Bleeding from erosions of the gastric mucosa has followed their use and has been severe ough in some instances to cause hematemesis and lena.[4] It has been suggested that interference h the protective mucous layer of the stomach ows this to happen. There is no evidence that ersecretion occurs, but the taking of aspirin has n followed by exacerbation of ulcer symptoms l occasionally by gastrointestinal bleeding.[5] The er patient with a cold should take salicylates with antacid, or preferably other means of symptotic relief should be found.

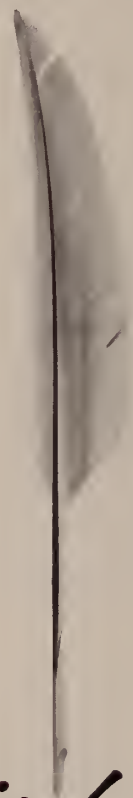
ffeine has two actions on gastric secretion. One ectly stimulates production of acid and the other entiates the out-pouring of gastric juice as a onse to other stimuli.[6] In high doses to animals, as produced erosive gastritis and peptic ulcera-. Caffeine-containing beverages are discouraged the ulcer subject and forbidden during an acute cerbation.[7] Many cold remedies contain caffeine.

sufferers from allergic rhinitis springtime brings iptoms of nasal obstruction, loss of taste and ll and malaise similar to those caused by viral ction but due instead to allergens which at that e of year are principally tree pollens. Relief from se symptoms can be obtained, though not wisely, the use of steroid medication. Unfortunately, nic sufferers from these allergies have used this roach with varying degrees of success. Steroid mones increase gastric secretion and delay the ling of experimental ulcers.[8,9] Clinically their inistration has been associated with reactivation healed duodenal ulcers, and with bleeding and foration which were not always preceded by cal ulcer distress. Because of these harmful cts, their use in the ulcer patient is best avoided other than serious medical problems and then with adequate antacid coverage.

ming up It is immaterial by which pathways malaise and lassitude, depression and irritability vate an ulcer, but it is the physician's responsiy to ensure that the medications he selects to ve the symptoms of a cold do not further aggra- the ulcer.

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Physician Candidates

Editor's Note: The 1966 state elections are of significant interest to the medical profession, in that a number of physicians have declared themselves candidates for statewide public offices. As of the March registration deadline, six members of the Florida Medical Association were running for positions in the Florida Legislature.

Because of legal delays brought about by reapportionment, The Journal was unable to determine the identity of physician-candidates until after the April issue had gone to press. When the names were obtained, each candidate was invited to submit, for publication in the May issue, an editorial describing his thoughts and feelings as a physician running for political office.

Despite the extremely short notice caused by publication deadlines, four of the candidates graciously prepared the following editorials, which The Journal is pleased to publish for the interest and information of its readers. Publication of the editorials does not imply Association endorsement of these candidates. Each physician has the responsibility to support and vote for all candidates of his personal choice.

A list of the FMA member-candidates and the offices they are seeking follows:

Senate

District 10—John J. Fisher, M.D., Jacksonville, obstetrics (R)

District 36—Samuel G. Latty, M.D., Winter Park, internal medicine (R)

House

Broward Group 7—David J. Lehman, M.D., Hollywood, internal medicine (D)

Dade Group 2—Franklin J. Evans, M.D., Coral Gables, general practice (D)

Dade Group 11—Walter W. Sackett Jr., M.D., Miami, general practice (D)

Hillsborough Group 9—Richard S. Hodes, M.D., Tampa, anesthesiology (D)

Reform Movement Needed

My decision to run for the State Senate in District 10 on the Republican ticket has both a predisposing and an exciting cause. The immediate reason, or acute stimulus that evoked such an action on my part, lies in the local political crisis in Duval County.

For years Jacksonville and its surrounding Duval County have been openly acknowledged to be controlled by a political machine with a single recognized individual sitting at the control panel. The area had formally progressed despite this, although not realizing the rate of progress displayed by neighboring cities less favorably endowed by geography or natural resources.

Recently even this rate of progress has slowed until it has ceased, with our schools being disaccredited, our tax structure upset, our health department becoming third rate, and new industry and new citizens looking elsewhere. Many people in this area have had enough and are ready for a reform movement.

My candidacy is to afford these citizens a clear issue in the general election in November that they can rally behind, without regard for the usual party boundaries or special interests, in order to save our community. If this objective is accomplished in the convincing fashion envisioned, others will be encouraged to complete the destruction of this political evil in our succeeding city and county elections next year.

The predisposing factor is of more general importance. It should be clear by now that private medicine needs representatives among the state and national legislatures to present its case as equals from the inside, rather than as special interest lobbies from without. This need shall become increasingly urgent with the many areas of commitment of state and national government in the field of health.

Less apparent, but equally important, is the reverse. Organized medicine needs its own physi-

cians within these legislatures where they can keep their fingers on the political pulse of our country. These physicians can relay our findings, almost as consultants, to our societies and associations, in order that we physicians may be better prepared to offer a realistic leadership in the field of health.

In short, by having physicians in our legislatures we can better present medicine's story to our lawmakers, and what is best for our country to our medical leaders. With the help of our fellow physicians we cannot fail. We cannot afford failure.

JOHN J. FISHER, M.D.
JACKSONVILLE

Why A Physician in the Legislature?

The whole nation is in the throes of a social and economic revolution. Education, hospital construction, medicare, antipoverty programs, aid to the handicapped, highway construction—all are recipients of federal aid and grants mainly because the states have lacked leadership in these spheres and have lost the initiative to the central government in Washington.

Now, the State of Florida is itself entering a new and historic era of political and socioeconomic reform. For the first time, legislative reapportionment has placed the leadership of the legislature where it should have been, in the hands of the counties with the most people. How well this leadership will be exercised is a matter for the future to determine.

The choice of representation in the legislature, therefore, becomes one of momentous importance. Ideally, there should be representatives from all segments of life—businessmen, farmers, professional men, housewives, merchants, salesmen, career women, bankers, and others. Is there a place for a doctor in this line-up? There most assuredly is. Why? By the very nature of his background and training, the doctor is a well educated, quick thinking, independent individual of mature judgment and stable character. His presence in the legislature could be of inestimable value. This is especially true when one learns that almost $300,000,000 is being spent in this state for health and welfare during the biennium 1965-1967 (nearly one third of the entire budget). Paradoxically, there is not, and has not been, a single doctor in the legislature for over a dozen years. With well over 6,000 physicians in Florida, it would seem the people are being deprived of real talent that is available for the legislature, and the medical profession is being deprived of deserved representation.

Furthermore, the physician's position in society has been placed in jeopardy by a harsh press, unsympathetic public and adverse and sometimes catastrophic court decisions. If he is to retain his position of eminence in society, the physician must have representation in legislative bodies of government so that he may show his versatility, contribute in a broader field of endeavor, and demonstrate to society that he is a dedicated citizen as well as an able physician.

Now, then, why Dr. F. J. Evans for State Representative? For most of the years I have spent in Dade County, dating back before World War II, I have given freely, willingly, and unselfishly of my time and efforts in the areas of professional, civic and public service. Time and space do not permit a recap of my record of service and accomplishments. (I am sure most of our members have some knowledge of these.) Suffice it to say that I have never shirked an assignment, have provided honest and efficient leadership, and have acquitted myself creditably in all my undertakings. I am certain I will do likewise as a State Representative. If elected, the Florida Medical Association will have its *own* Speaker of the House of Delegates in the legislature to guide its legislative programs, and one who will heed advice and conduct himself in a manner that will take into consideration the best interests of all of the people of Florida.

FRANKLIN J. EVANS, M.D.
CORAL GABLES

Is There A Doctor In The House? There Should Be!

My decision to become a candidate for the state House of Representatives was not made hastily. I considered at length the personal problems which would result, not only if I am elected, but from my active candidacy as well.

Being a political candidate is both time-consuming and costly. First, there are the day-to-day handshaking, the speaking and the general requirement of getting yourself and your views known to the voters. It takes time. A great deal of it. Then there is the necessity of keeping right on top of a myriad of local and state issues. This means doing a tremendous amount of research and reading in order to be able to speak knowledgeably about each issue and to offer constructive criticism where it is needed. All this is in itself a full time job, yet it must be accomplished without letting it interfere with my active practice in internal medicine.

Financially, I was far better off to turn my back on the campaign trail. A man who serves the state as a member of the Florida Legislature receives a salary of only $1,200 annually.

I weighed all these factors against the obvious need for the voice of a physician to be heard in the State Legislature. With the tremendous number of bills pertaining to medicine that are sure to come before the legislature, it is of utmost importance that someone familiar with these issues have a hand in the formation of this type of legislation.

After considering the personal cost of becoming a candidate against the inescapable fact that physicians seem to have the poorest record of influencing legislation, and realizing the tremendous impact Medicare is going to have on our state, I decided that as a physician I cannot put off accepting the obvious responsibility we in the medical profession have in the legislative area.

This responsibility, far from diminishing, is becoming more and more evident. Physicians seem to suffer from the greatest ignorance of social problems. They seem to view every item of social legislation in terms of their personal practices. It is very unusual to find physicians in politics; yet there is a definite need for them in the legislature.

As time goes on, there may be more Medicare-type legislation and increasing amounts of federal funds coming to the state for medical purposes. Whether we as physicians favor these programs or not, once they become law it is up to us to see that the states take advantage of the funds which the Congress makes available.

It is becoming increasingly obvious that the states will have to pass enabling legislation to administer many of these programs. This will require the assistance of someone in the field. There is no reason why we physicians must remain in the background and act as consultants to the State Legislature on these matters. Too often our advice is sought, listened to and then ignored. But advice from a physician who is speaking as one legislator to another is not so easily overlooked.

There is a tremendous need in our state for a comprehensive educational program on health insurance. It is needed by both the physician and the general public. By and large the medical profession has resented the intrusion of a third party into the economics of medicine. This third party is the insurance company. This resentment is the basic factor that has created resistance to a health insurance education program on a statewide basis.

The medical profession will, I believe, be more inclined to listen to me when I am speaking as a legislator than when speaking as a private physician or as chairman of the Florida Medical Association's Committee on Health Insurance.

I would also recommend to the State Insurance Commissioner that he require individual insurance companies or the Health Insurance Council of Florida to undertake a program of health insurance education for the public and that a committee be organized at the state level to coordinate this education program. The great variety of insurance policies that are available plus the wide range of costs of health insurance makes it imperative that we have this program of education.

As a state legislator I will be in a better position to recommend to the State Insurance Commissioner that he open avenues of communication

between his office, the Health Insurance Council of Florida and the Florida Medical Association.

There will be many ramifications of state health problems of which we are not yet aware. As a legislator I will be in a position to be heard by men elected from all over the state and I will not have to sit back and wait until they seek out my advice on matters pertaining to medical legislation. It will be my responsibility as an active physician and an active lawmaker to let THEM know what is best.

If more health programs become nationalized, it will be necessary for the states to take an increasing role in the administration of these programs. There will be problems of matching funds, uniform administration throughout the state, local initiation, all of which often are an integral part of federal plans. I do not as yet know what the state's legislative role will be in these national health programs, but it is obvious the state will have one and it will take knowledgeable physicians to expedite this role.

The problems I anticipated meeting as a candidate all have materialized. To campaign for the state legislature is a demanding role which leaves little time for family or leisure. But physicians can no longer afford to take a back seat in politics, no matter what the personal sacrifice. Traditionally, they have waited until the final, public hearing stage and come out strongly in a "too little and too late" move to make their opinions felt.

Politics is something that involves all citizens interested in good government. There should be more activity on the part of the nonprofessional politician, rather than less, if we are to have sound, well rounded government truly representing the interests of the people.

It is apparent to me that the time has come when we must answer that familiar query, "Is there a Doctor in the House?" with a resounding "Aye."

David J. Lehman Jr., M.D.
Hollywood

Old Cliché

It may be an old cliché that a person gets out of government only what he is willing to put into it, but it most certainly applies to doctors. Early in my medical career I became aware of the fact that doctors shun politics and leave the government functions to the other professional groups. It is well documented that this attitude has worked to medicine's disadvantage as well as to that of the general public. It probably was this 'slam' on medicine that prompted me to consider, several years ago, the possibility of entering into state politics and I barely missed running for the 1964 legislature. Since I have had more encouragement at this time from my family, friends, patients and associates, I have entered the race for the House of Representatives. It seems appalling that, in a business in which one third of the budget refers to health matters, not one person is adequately conversant with such phases of public life and able to offer advice to either house of the legislature. It seems equally surprising that this lack goes back to 1945 when the last doctor appeared in the Florida legislature. In fact, in the years since 1917 there have been scarcely more than 10 doctors in the legislature.

Having entered the race, I am struck by the fact that the legal profession has seemed to usurp the spots in the legislature and would, at least in our county, take all positions if it were possible to do so. While this goal may not be unseemly, inasmuch as lawyers are adept at interpreting and hence writing the law, it would still seem most unfortunate that more professions are not represented in the Florida State Legislature. I was told the other day that there is not a single CPA in the legislature. This is indeed a surprising situation. What astounded me more than the matter of super abundance of lawyers occupying the spots pointed toward the legislature was the fact that many or most of them are in the younger years, mostly between 30 and 45 and a number of them under 30. This age range would seem to be an indication either that they think they have more to offer or that their professional activities

will not suffer if they spend a good bit of their time in governmental positions.

While I received much praise for being involved in this race, I regret that my age is not more comparable to that of my lawyer opponents. I hope that in future years we will be able to persuade some younger doctors to enter into political pursuits. As I survey my four fellow doctors running for similar spots from counties around the state, I heave a sigh of great satisfaction in that they too have somehow been inspired much as myself. I hope that each year similar endeavors on the part of public-minded doctors will increase.

Yet, with doctors constantly bemoaning the lack of interest of their cohorts in politics and with various outstanding members urging constantly for such participation, it is shocking to experience the lack of encouragement and outright support forthcoming to those of us who have had the courage to make the plunge. I am sure that, with such an attitude prevailing, the old cliché will continue to apply until a new breed of doctors arrives on the scene.

Walter W. Sackett Jr., M.D.
Miami

Home Care

All who are concerned with the care of patients realize that our present hospital bed shortage will become acute during the summer when Public Law 89-97 (Medicare) is activated. Who can

See "Home Care Program," page 391

predict the extent of this shortage? Hospital utilization committees created to conform to the requirements of Medicare will discourage unnecessary admissions and prolonged stays—we trust. It is hoped that the physicians of Florida will exhibit their best judgment and restraint in their demands upon our hospitals. Nonetheless there will be a crippling shortage of hospital beds unless these beds are maintained and reserved for those patients requiring relatively intensive care.

If we could only shorten the average hospital stay we would be able to provide beds for more patients—of all age groups. Many patients, particularly in the older age group, are kept in the hospital a few extra days (or even weeks) simply because there is no one at home capable of rendering even basic health care. A few of these patients have been cared for in nursing homes, and this trend will doubtless continue despite the relative expense.

The obvious solution to this problem lies in the development and utilization of Home Care Programs. The Home Care concept is one of a physician-directed health facility for the patient in his own home. The basic ingredients for such a plan and the two required for approval by Medicare are (1) the Visiting Nurse and (2) Home Health Aides (Homemakers). Physical therapy, speech therapy, laboratory, social service, and other facilities suitable for the patient at home could be added. It must be stressed that appropriate patients would have to be referred to Home Care by their physicians. Likewise, it must be the physician who would direct the type and extent of services. The traditional responsibility of the doctor to his patient will thereby be preserved. Furthermore, for approval by Medicare it must be the physician who refers the patient to Home Care. Home Care patients who are not recipients of Medicare should pay for this service as they would for any other medical service, and those unable to do so might have this service paid by their local welfare agencies.

These programs will not only free needed hospital beds but also will allow the doctor some assurance that the patient is getting the proper diet, living under hygienic conditions, and following medical orders. The majority of the work done would be by the Home Health Aides, and the nurse's visit would be only as necessary. Her reports to the doctor would free him from routine house calls.

At present there are three basic patterns along which Home Care Programs may be developed.

One concept has been presented by Drs. Shapiro and Purdue in their description of the experiences of a hospital-related program at Jackson Memorial Hospital in Miami.

The community concept would utilize a board of directors selected from the community. It would be the duty of this board to set the policies of Home Care in the area and to secure the necessary executive personnel who in turn would maintain the quality and quantity of nursing and health aide personnel. The board of directors would also contract for other paramedical services as necessary. Any financial deficits in such a program would logically be borne by the community through its United Appeal or similar agency.

The Public Health Department might logically assume the responsibility in communities which might not have the necessary ingredients to launch such a venture. At present the Public Health Department directs the Visiting Nurse Program in some of these areas. Only in those areas which do not have the elements for establishing a good Home Care Program by the community or hospital should the responsibility be borne by any branch of government. Today there is money available through federal grants to hospitals, communities, and public health departments for the establishment of Home Care facilities.

The Florida Medical Association has advocated the establishment of Home Care agencies for the past three years and has urged its members and the members of its Woman's Auxiliary to exert leadership in developing these programs, but as yet there are less than a handful in Florida. Now a crisis faces us and we are not prepared for it. Unless we assume leadership and responsibility in this emergency it will pass to others. In this case who can doubt who "others" will be? It takes time to obtain community support, plan and activate these programs. Time is fast running out. The doctors of every community must act—and act now.

William R. Daniel, M.D.
Orlando

Medical Education Loan Guarantee Program

The American Medical Association Education and Research Foundation released a progress report through December 31, 1964 on its Medical Education Loan Guarantee Program. Since the program began in March 1962, there had been 19, 298 loans approved with a principal value of more than $22,000,000. Medical students, interns and residents all received loans in greater number in 1964 than in 1963 with residents showing the sharpest increase. Among medical students, a slight decline in the number of loans to freshmen and sophomores was more than offset by increases in the two upper classes.

Medical trainees in California borrowed more frequently than those in any other state, with Texas, Tennessee, Pennsylvania and District of Columbia following in order. Florida trainees received 246 loans amounting to $295,400 in 1964 in contrast to 176 in the amount of $214,400 in 1963.

Eighty medical schools had borrowers in 1964 with Texas (Galveston), Tennessee and Indiana leading. In Florida, trainees at the University of Florida College of Medicine received 51 loans totaling $57,700 in 1964, a substantial increase over the 31 loans amounting to $37,200 in 1963. The figures for the University of Miami School of Medicine were 64 loans in 1964 totaling $76,300 and 53 loans in 1963 amounting to $65,700. More than 500 hospitals had interns and residents borrowing from the program in 1964.

NEWS

FMA Member Receives Honorary Law Degree

Dr. Clyde O. Anderson, St. Petersburg, received an honorary doctor of law degree from the University of Florida during the annual commencement convocation April 24 in Gainesville.

Dr. Anderson, recipient of the 1965 A. H. Robins award, has practiced medicine in St. Petersburg since 1934. He is president of the UF Foundation, and served for 11 years as president and chairman of the executive committee for the UF Endowment Corporation, a forerunner of the foundation.

Anclote Manor Symposium Held

The Anclote Manor Foundation held its Third Annual Scientific Symposium, April 9 in Tarpon Springs.

The featured speaker was Dr. Howard P. Rome, president of the American Psychiatric Association. Dr. Rome is a senior consultant in psychiatry and past staff president at the Mayo Clinic, editor of American Lecture Series in Clinical Psychiatry and has authored 76 professional and technical papers, chapters and articles. His topic was "Changing Patterns in Psychiatric Care."

Reserve Commissions Open to Physicians

Physicians with no prior military service may now receive commissions in the Air Force Reserve to fill vacancies in reserve medical units, according to Col. James B. Hall, of Mount Dora.

The restriction on direct commissions for physicians was removed in March to allow doctors to fulfill their military obligations through participation in ready reserve medical units. The restrictions on non-prior service physicians likely will again be placed in effect when the next physician draft call is implemented, Col. Hall stated.

Qualified physicians with no prior service who anticipate military service may receive further information by contacting Col. Hall at 121 S. Sinclair Street, Tavares 32778 or the Reserve Affairs Officer, Patrick AFB, or their local Air Force reserve recruiter.

ACS Conducts Cancer Program

The American Cancer Society is conducting an intensive education program aimed at rectal and colon cancer, the second largest cancer mortality source in the country.

Publications, films, flyers and exhibits for use in physician's educational programs are available through the Florida Division, ACS, 2909 Bay-to-Bay Boulevard, Tampa 33609.

Emory Announces Urology Chair

Emory University has announced a chair in urology to be established in memory of an alumnus, the late Louis M. Orr, M.D., Orlando.

Dr. Orr had practiced in Orlando since 1927 and served as president of the AMA in 1959-1960. He traveled over 600,000 miles and delivered many speeches against government interference in medicine.

Dr. Orr was also former president of the southeastern section of the American Urological Association and a member of the American Board of Urology.

Sleep Research Meetings Held

More than 100 of the world's investigators of the mysteries of sleep converged on the University of Florida Gainesville campus March 24-27 to exchange information on current sleep research.

The researchers from major sleep research centers in the U.S., Germany, France and Italy gathered for the second annual symposium of the Association for Psychophysiological Study of Sleep, the only inter-disciplinary scientific body devoted exclusively to the subject.


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The introduction of Flagyl removed both of these long-standing deficiencies. Hundreds of published investigations in thousands of patients have confirmed the ability of Flagyl to cure trichomoniasis.

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Dosage and Administration

In *women:* one 250-mg. oral tablet t.i.d. for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When the inserts are used one vaginal insert should be placed high in the vaginal vault each day for ten days, and concurrently two oral tablets should be taken daily.

In *men:* in whom trichomonads have been demonstrated, one 250-mg. oral tablet b.i.d. for ten days.

Contraindications

Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precautions and Side Effects

Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

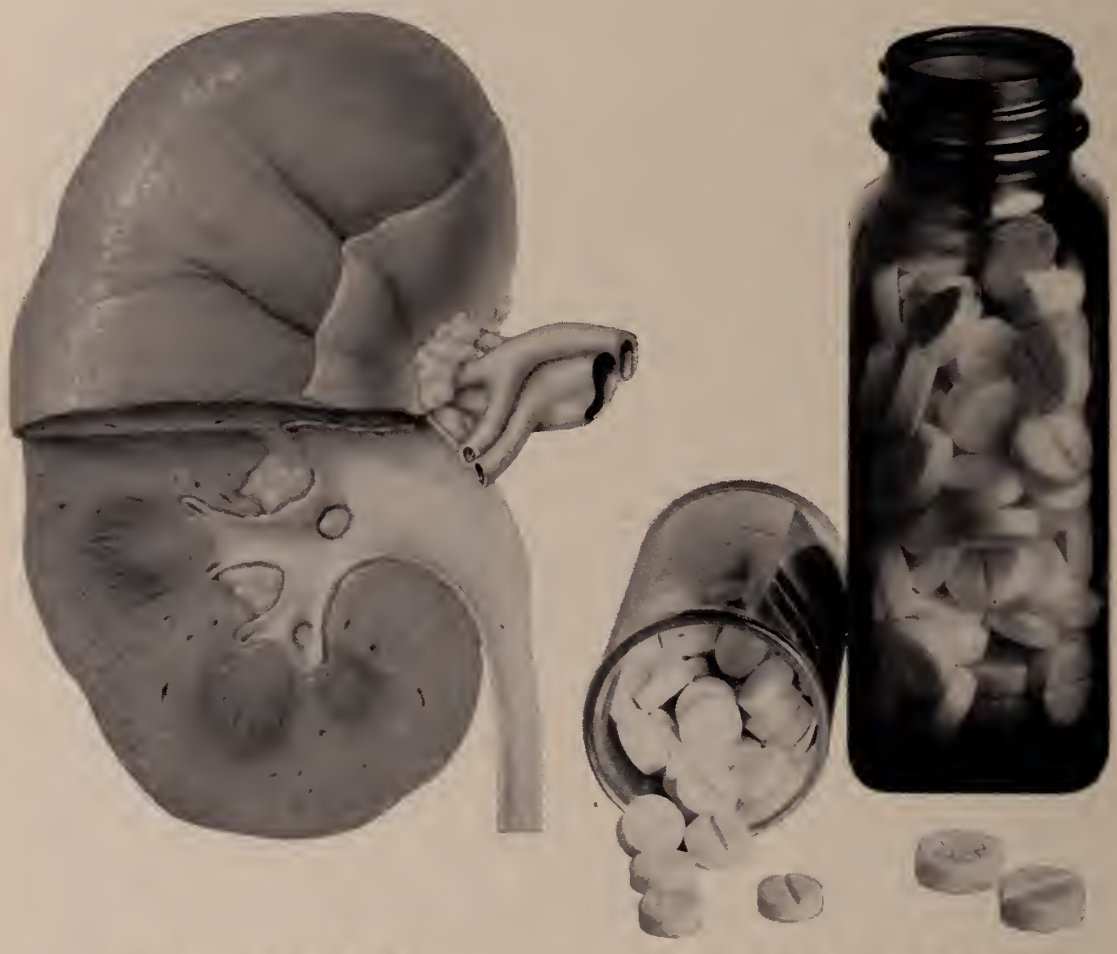
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SEARLE

Research in the Service of Medicine

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understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

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Contraindications: Contraindicated in patients sensitive to sulfa or penicillin, pregnant females at term, premature infants, newborns during first week of life. **Precautions:** Watch for hypersensitivity reactions and overgrowth of nonsusceptible organisms. Observe usual precautions for sulfonamide therapy: adequate fluid intake; force fluids if urine volume is low; maintain urinary pH of 7 or higher; use only after critical appraisal in patients with liver or renal damage, urinary obstruction, blood dyscrasias. **Adverse Reactions:** Anaphylactoid shock (rare), G.I. disturbances, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, urticaria, purpura, hematuria, crystalluria, conjunctival and scleral varicula, petechiae may occur. **Dosage:** Daily pediatric dosage should supply 65-100 mg. trisulfapyrimidines per pound body weight in divided doses q. 4 to 6 h. **Supply:** Pentid-Sulfas for Syrup when prepared, provides 80 cc. (16 doses) or 150 cc. (30 doses) of fruit-flavored syrup providing in each 5 cc. teaspoonful 125 mg. (200,000 u.) potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine.

Now . . . **NEW PENTID® '400'—SULFAS FOR SYRUP** (buffered penicillin powder with sulfadiazine, sulfamethazine, and sulfamerazine each 5 cc. providing 250 mg. [400,000 units] potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine). Available in 16-dose (80 cc.) and 30-dose (150 cc.) bottles.

For full information, see Product Brief.

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Effective in a wide range of everyday infections —respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Warning — In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of discomfort.

Precautions and Side Effects — Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

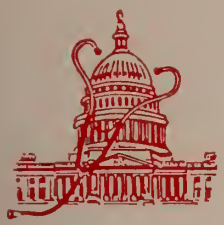
Capsules: 150 mg of demethylchlortetracycline HCl.

Tablets: film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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Government News

Medicare Carriers Selected

The selection of 48 organizations in the health insurance field to serve as contractors to pay doctor bills under the Medicare program was announced February 10 by Robert M. Ball, Commissioner of Social Security.

Among the organizations selected are 32 Blue Shield plans, 15 insurance companies and one independent health insurer. The selected Blue Shield plans will serve 59 per cent of the nation's Medicare beneficiaries; the insurance companies, 38 per cent; and the independent insurer, 1 per cent.

Blue Shield of Florida, Inc. has been selected carrier for the state of Florida. Designations have not yet been announced for Virginia, the Virgin Islands, Guam, and American Samoa, which will account for the remaining 2 per cent of Medicare beneficiaries.

The selections announced, Mr. Ball said, are designed to provide the most effective and efficient administration of the medical insurance part of the Medicare program. Also, they broadly represent the variety of health insurance organizations now in operation throughout the country. This will permit comparison of their performance in accordance with the intent of the Congress.

The medical insurance part of the Medicare program will pay 80 per cent of the older person's doctor bills, plus a variety of other medical services above an annual deductible of $50. More than 12 million people 65 and over have already enrolled for this coverage to supplement the hospital insurance they will have under Medicare, beginning July 1. The deadline for enrollment in the medical insurance program was March 31 for anyone who reached 65 before the beginning of this year, Mr. Ball pointed out.

In enacting Medicare legislation, the Congress noted the store of experience built up by private insurance companies, voluntary medical insurance plans, and group health prepayment plans in the reimbursement of physicians, Mr. Ball said. The law therefore provides for contracting out to nongovernmental organizations, to the extent possible, the administrative functions connected with the payment of physicians' bills and certain other health services for persons enrolled in the voluntary medical insurance program. The contractors named will receive and pay physicians' bills of older people signed up for the voluntary medical insurance under one year contracts, subject to renewal upon satisfactory performance. "At this point," Mr. Ball said, "the selection of contractors is tentative, subject to agreement on contract conditions between the individual organizations and the Government."

PL 89-97 Panel

Editors note: The following information is abstracted from physicians' written questions submitted following a panel discussion of Medicare during a recent meeting of the Medical Association of Georgia and answered by James W. Murray, regional assistant commissioner and Douglass M. Richard, regional representative, Bureau of Health Insurance, Social Security Administration, Department of Health, Education, and Welfare, Atlanta.

T.M.

WHAT IS DEDUCTIBLE UNDER THE SUPPLEMENTARY MEDICAL BENEFITS PLAN (PART B) OF MEDICARE?

The total amount of expenses incurred by an individual under part B during a calendar year will be reduced by a deductible of $50.00. The deductible for such a calendar year may be reduced by the amount of any expenses incurred in the last three months of the preceding year. The deductible applies to total expenses and not to each physician's fee. After the deductible has been met, payment can be made by a carrier for 80 per cent of the reasonable charges for the physician's (or other) services (1) to the patient on the basis of a receipted bill or (2) to the physician upon his acceptance of an assignment from the patient, with the understanding of the physician that the reasonable charge determination will be accepted as the total amount of his bill.

WHAT IS THE DIFFERENCE BETWEEN AN "INTERMEDIARY" AND A "CARRIER"?

An intermediary is a public or private organization which serves as the government's contracted agent to reimburse for expenses covered by the hospital insurance part of the program (part A). A carrier will make payments for the reasonable charges of physician's and other medical services under part B.

CAN A PHYSICIAN "PARTICIPATE" WITH SOME PATIENTS AND CHOOSE TO BILL OTHER PATIENTS AS USUAL?

If "participate" means to accept assignment by the patient for direct payment from the carrier, the answer is yes. It is entirely the physician's choice whether to accept assignment or to bill the patient in the regular way. In accepting assignment, the physician must agree that the amount determined by the carrier as a reasonable charge will be accepted as the full amount of the bill.

WILL THE POST-HOSPITAL HOME HEALTH CARE PROVISION UNDER PART A PAY THE PHYSICIAN'S FEE?

No. Physicians' services are covered under part B.

HOW WILL THE CARRIER DETERMINE "REASONABLE CHARGES"?

In determining reasonable charges, the carriers will have to consider the customary charges for similar services generally made by the physician or other persons or organizations, and also the prevailing charges in the locality for similar services.

IS IT TRUE THAT A HOSPITAL WHICH HAS NOT SIGNED THE CIVIL RIGHTS COMPLIANCE AGREEMENT IS NOT ELIGIBLE FOR MEDICARE? WILL THE PHYSICIANS' BILLS BE PAID EVEN THOUGH THE HOSPITAL BILL IS NOT?

Hospitals and other providers of services under part A must be in full compliance with Title VI of the Civil Rights Act. Payment for physicians' services under part B is not affected by the Civil Rights Act.

WHO DECIDES ON THE ACCEPTABILITY OF THE UTILIZATION REVIEW PLAN?

The state agency will recommend to the Secretary those hospitals having a utilization review plan that meets the basic legal requirements of the law.

WHAT STEPS ARE BEING TAKEN FOR CERTIFICATION OF PRIVATE LABORATORIES?

The Administration is completing work on the standards the state agency will apply in determining whether private laboratories meet the basic conditions for participation in the program.

Health Careers Guidebook

Words like "cytotechnology" may be as meaningless to the newcomer to the health field as "supercalifragilisticexpialidocious" is to the Mary Poppins set, but career seekers soon learn that it is a newly minted name for the study of human cell functions. Cytotechnology is one of some 200 health occupations discussed in the new edition of the U. S. Department of Labor's Health Careers Guidebook.

The updated handbook gives general information on the established health occupations, tells the nature of the work performed, gives training and licensing requirements, tells what future job prospects are, gives an indication of salaries and working conditions, outlines the personal qualifications required, and lists sources of additional information about specific health careers.

Job openings in the health services field are expected to grow by more than 500,000 in the next five years, and perhaps leap to some 900,000 by 1975. A combination of social programs such as Medicare, and continued advancement in health research are reasons to believe that the field's rate of growth will continue to increase in the years ahead.

This rapid increase creates a problem because, in the opinion of most informed persons, there are far from enough qualified people entering the field to fill all of the vacant jobs. One answer to this problem is to create more interest in young people who are about to choose a career. The Guidebook is a step in the government's effort to recruit young people for health careers.

Designed primarily as a counseling tool for youth, the Guidebook has an attractive format, and is easy to read and understand. It has 251 pages of information and more than 75 illustrations.

The Guidebook may be purchased from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402. The price is $1.50.

NIMH Reorganization

The first major reorganization of the National Institute of Mental Health in the 18 years of its existence was approved and announced March 11 by Dr. William H. Stewart, Public Health Service surgeon general.

The new NIMH structure will make possible more effective and flexible use of federal funds in support of all parts of the new national mental health program, according to Dr. Stanley F. Yolles, director.

The growth of the Institute's program is reflected by the 1967 budget request of $303 million contrasted to its original 1948 budget of $4 million. Dr. Yolles stated the new plan of organization will give more emphasis to clinical research, prevention programs, evaluation of treatment methods, innovative and experimental training programs and epidemiological studies, as well as mounting an extensive attack on special mental health problem areas.

The new administrative structure establishes:

1. Four specialized program operations within the NIMH as centers for the study of alcoholism, narcotics and drug abuse, suicide prevention and metropolitan mental health problems.

2. Four centers to coordinate all Institute activities for the study of schizophrenia; mental health and social problems (such as automation, divorce, sex deviation, poverty, race relations, leisure time); mental health of children and youth and crime and delinquency.

3. Two model community health centers: one focused around a general hospital, the other based on a large state mental hospital.

4. Five associate directorships, which will administer NIMH activities in the areas of extramural research, manpower and training, mental health service programs, field investigations and intramural research.

The Institute will also sponsor experimental and special job training programs for professional and nonprofessional personnel. Continuing education programs for general practitioners and mental health professionals, including psychiatrists, will be expanded.

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Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be virtually free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

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Krebiozen Warning

The American Medical Association and the Food and Drug Administration warn the public against interpreting the acquittal of the promoters of krebiozen as meaning it is effective in the treatment of cancer.

A federal court jury in Chicago found the promoters not guilty of fraud.

"The results of a criminal proceeding should not be interpreted as establishing efficacy of the alleged new drug called krebiozen by its promoters," the AMA said. "Cancer sufferers should consult with their physicians and not try to determine for themselves what is the best course of treatment in their own individual cases."

"As far back as 1963, krebiozen was proved to be nothing more than mineral oil and creatine, a common laboratory chemical," the FDA said. "That scientific judgment still stands. The FDA will carry out its responsibility to the public by doing whatever will be necessary to keep krebiozen out of interstate commerce. We will do this as a life-saving activity. Each day a person with treatable cancer relies upon krebiozen is a day that brings him closer to death."

Medicare Bureau

A new Bureau of Health Insurance to administer the Medicare program was established by the Social Security Administration on December 2, 1965. Arthur E. Hess, formerly director of the Division of Disability Operations, was named director of the new bureau.

The BHI has appointed a regional representative in each of the nine regional areas throughout the country to coordinate program activities. The regional representative for Alabama, Florida, Georgia, Mississippi, North and South Carolina and Tennessee is Douglas M. Richard, Room 404, 50 Seventh Street, NE, Atlanta, Georgia 30323, phone (404) 526-5226.

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Dosage: One or two tablets, one-half hour before bedtime.

Indications: For night-time sedation and refreshing sleep up to eight hours.

Contraindications: Patients sensitive to barbiturates. Use with caution in the presence of moderate to severe hepatic disease.

Supplied: Bottles of 100 tablets.

CAUTION: Federal law prohibits dispensing without a prescription.

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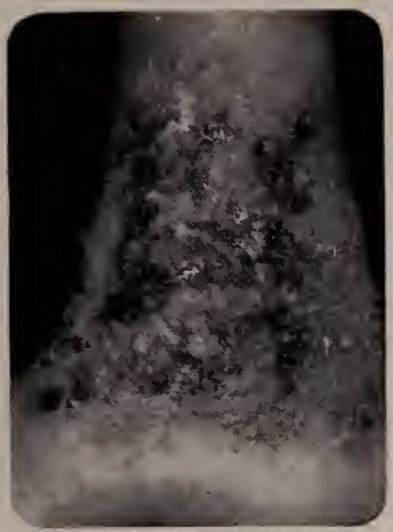
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Pentobarbital Sodium	25 mg.
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R. R., Age 11—Before treatment—atopic eczema of long standing



After treatment—with ARISTOCORT Topical Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of childhood eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Packages: Tubes of 5 Gm. and 15 Gm.; ½ lb. jar.

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- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
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Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

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Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

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DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

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Anorectic
Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day. They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

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Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



Front Side

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
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Front Side

samples available



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economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

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1966 Regional Symposium on Strokes

PRESENTED BY THE DEPARTMENT OF NEUROLOGY, UNIVERSITY OF MIAMI SCHOOL OF MEDICINE, May 16 and 17, 1966, EDEN ROC HOTEL, MIAMI BEACH, FLORIDA

program

May 15, Sunday

6:00 PM - 10:00 PM Registration.

May 16, Monday

8:00 AM Registration
9:00 AM Introduction to the Problem and Clinical Classification of Cerebral Vascular Disease — P. Scheinberg
9:45 AM Cerebral Circulatory Physiology in Cerebral Vascular Disease — O. M. Reinmuth
10:15 AM Review of Functional Vascular Anatomy of Brain — C. M. Fisher
10:45 AM Break (15 minutes)
11:00 AM Transient Ischemic Attacks.
I. Definition and Symptoms — S. Shafey
11:30 AM Transient Ischemic Attacks.
II. Pathogenesis & Prognosis — N. J. David
12:00 Noon Question and Answer Period for Morning Speakers
Panel — Reinmuth, Fisher, Shafey, David
Moderator — P. Scheinberg
12:30 PM Lunch
2:00 PM Transient Ischemic Attacks.
III. Diagnosis and Clinical Tests — O. M. Reinmuth
2:30 PM Transient Ischemic Attacks.
IV. The Value of Anticoagulants in Treatment — C. Millikan
3:00 PM Transient Ischemic Attacks.
V. The Value of Vascular Surgery in Treatment — D. Warren
3:30 PM Break
3:45 PM Transient Ischemic Attacks.
VI. Treatment by Ancillary Methods — N. J. David
4:15 PM Question and Answer Period
Panel — Millikan, Warren, David, Reinmuth
Moderator — P. Scheinberg

May 17, Tuesday

9:00 AM The Accomplished Stroke.
I. Differential Diagnosis and Mechanisms of Recovery — C. M. Fisher
9:30 AM The Accomplished Stroke.
II. Management and Prognosis — C. Millikan
10:00 AM Cerebral Hemorrhage.
I. Incidence, Related Diseases, and Clinical Diagnosis — H. H. Merritt
10:30 AM Break
10:45 AM Cerebral Hemorrhage.
II. Management and Prognosis — S. Shafey
11:15 AM Subarachnoid Hemorrhage.
Etiologies and Management — L. Pool
12:00 Noon Question and Answer Period
Panel — Fisher, Millikan, Merritt, Shafey, Pool
Moderator — P. Scheinberg
12:30 PM Lunch
2:00 PM Neuro-ophthalmological Aspects of Cerebrovascular Disease — J. L. Smith
2:30 PM Rehabilitation and Use of Ancillary Services — W. J. Erdman
3:15 PM Break
3:30 PM A Summing Up — P. Scheinberg
4:00 PM Question and Answer Period
Panel — Smith, Erdman
Moderator — P. Scheinberg

guest faculty

William J. Erdman, II, M.D.
Professor and Chairman of Physical Medicine and Rehabilitation
University of Pennsylvania School of Medicine
Philadelphia, Pennsylvania

C. Miller Fisher, M.D.
Assistant Clinical Professor of Neurology
Harvard Medical School
Boston, Massachusetts

H. Houston Merritt, M.D.
Professor of Neurology
Dean, College of Physicians and Surgeons
Columbia University
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Mayo Clinic and Mayo Foundation
Professor of Neurology
Mayo Graduate School of Medicine
(University of Minnesota)
Rochester, Minnesota

J. Lawrence Pool, M.D.
Professor and Chairman
Department of Neurosurgery
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Professor and Chairman
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Miami, Florida



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In rheumatoid arthritis—effective thera with minimal chance of G-I upset

Therapeutic Effects
Fifty to 75% of patients obtain major relief of arthritic symptoms, as reported by numerous clinicians. In addition, the problem of gastric upset—a major problem with certain other oral antiarthritic agents—is minimized by the presence of antacids and an antispasmodic in the formulation.

Improvement is generally seen within 3 to 4 days, and trial therapy need not be continued beyond a week. Relief of pain is followed quickly by resolution of inflammation and improved joint function. Relief of symptoms is often accompanied by increased appetite, gain in weight and an improved sense of well-being.

The initial response is usually maintained without dosage increases; indeed, initial dosage is often reduced for maintenance purposes.

Salicylate or steroid therapy can usually be diminished or, in some instances, eliminated.

Contraindications
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid rea have been reported but cannot defir attributed to the drug. Thrombocyto purpura and aplastic anemia are als sible side effects. Confusional state agitation, headache, blurred vision, neuritis and transient hearing loss h been reported, as have hepatitis, jau and several cases of anuria and hem With long-term use, reversible thyro hyperplasia may occur infrequently.

Average Dosage in Rheumatoid Art
Initial: 3 to 6 capsules daily in divide It is usually unnecessary to exceed sules daily. A trial period of 1 week i quate to determine response; in the of favorable response, discontinue.

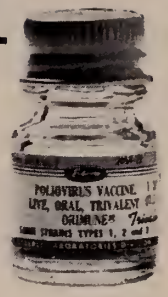
Maintenance: An effective level is o achieved with 1 to 2 capsules daily; exceed 4 daily.

Also available:
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Tablets of 100 mg.

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ORIMUNE® TRIVALENT

POLIOVIRUS VACCINE, LIVE, ORAL SABIN STRAINS TYPES 1, 2 and 3

Fast, simple administration—and economy for the patient—make the new 0.5 cc single-dose vial of ORIMUNE Trivalent ideal for private practice. (Packaged 5 to a box with 5 sterilized disposable droppers for your convenience.)
(Also available in 2 cc and 2 drop dosage forms.)

Only 2 doses required for complete, initial immunization for patients more than a year old. *Effectiveness*—may be expected to confer active immunity against all three types of poliovirus infection in at least ninety percent of susceptibles only if given at full dosage, as directed. No characteristic *side effects* have been reported. There are, however, certain *contraindications*. These are, broadly: acute illness, conditions which may adversely affect immune response, and advanced debilitated states. In these, vaccination should be postponed until after recovery.

In infants vaccination should not be commenced before the sixth week of life. Do not give to patients with viral disease, or if there is persistent diarrhea or vomiting. ORIMUNE and live virus measles vaccine should be given separately.

Dosage—initial immunization: two doses each given orally at least 8 weeks apart. (Give a third dose to infants at 10-12 months.) Booster immunization: one dose, given orally. See package literature for full directions.

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ARE YOU ALL SET?

92nd Annual Meeting

May 12-15

Diplomat Hotel

Hollywood Beach

Association News

Current Medical Issues

No organization, political or professional, functions without the cooperation of its membership. In order to function effectively within the framework of the organization, each member must be informed. At the FMA Annual Meeting, May 12-15, the House of Delegates will meet to decide the official position of the FMA on current issues facing the medical profession.

As a member physician of the FMA, these issues and decisions are of direct importance to you.

The following topics coming before the House of Delegates for decision are here presented so that you, as a functioning member of the FMA, may be informed and prepared to voice your opinion:

Physician Remuneration by Government Agencies

Resolutions strongly favoring payment to physicians of the usual and customary fees prevailing in their area by all government agencies and by government sponsored or guided plans at all levels, sponsored by the Alachua, Broward, Dade, Duval, Orange and Polk county medical societies.

Pathologists and Radiologists Charges for Services

Resolutions approving the separation of professional fees and hospital charges for the services of pathologists and radiologists, sponsored by the Broward and Dade county medical associations. These resolutions concur with the AMA House of Delegates approved policy stating fees for services of hospital based specialists should not be merged with hospital charges.

Anti-Quackery Legislation

Resolution by the Broward County Medical Association that legislation establishing an agency to investigate, publish findings and prosecute quackery is desirable in Florida.

Opposition to Hart Bill

Resolution by the Dade County Medical Association opposing the Hart Bill on the grounds that while purporting to correct abuses in the practice of medicine, the bill actually contains restrictions to defeat this purpose.

Motorcycle Safety Program

Resolution by the Marion County Medical Society that the FMA advocate instructional programs and use of safety equipment for motorscooter, motorbike and motorcycle operators and support legislation making these mandatory.

Support of Blue Shield

Resolution by the Orange County Medical Society that Blue Shield of Florida be maintained and strengthened in every way possible.

Scientific Program

Recommendation by the Scientific Council that the FMA's entire scientific program be strongly endorsed and strengthened.

Third Medical School

Recommendations against the establishment of a third medical school until both present medical schools are being utilized to fullest capacity by the Council on Medical Education and Hospitals and the Council on Legislation and Public Agencies. The Council on Medical Education and Hospitals further urges that the FMA be involved in the formation of any future medical school, including the proposed medical school at the University of South Florida.

The following recommendations come from the Council on Medical Services and are presented as summaries.

Home Care Programs

The FMA Woman's Auxiliary is to undertake active promotion and establishment of comprehensive home care programs including local homemaker services.

Nursing Home Certification

The State Board of Health is urged to provide physicians and hospitals with certification of all nursing homes by degree and type of care available in order to bring about and maintain higher standards of care.

Revised Abortion Law

Recommendation that a revised abortion law, utilizing the American Bar Association and American Medical Association approved model law as a basis, be introduced in the 1967 session of the Florida Legislature.

Human Sterilization

Revision and updating of hospital regulations pertaining to human sterilization.

Venereal Disease Education

Counties having venereal disease education in the schools are encouraged to continue and counties not having such education are urged to adopt it, and county medical societies are urged to initiate such education programs for their members and local teachers.

Pasteurization Law

Recommendation that a bill be introduced in the 1967 session of the Florida Legislature establishing a statewide pasteurization law outlawing the sale of raw milk.

Tuberculosis Hospital Closure

The State Tuberculosis Board is urged to withhold any decision to close a tuberculosis hospital.

PKU Testing

Support is urged for voluntary statewide PKU testing program and physician and hospital cooperation is encouraged.

State Mental Hospital

Recommendation that the FMA oppose the establishment of a state mental hospital in Hernando County.

Involuntary Hospitalization

Recommendation that re-enactment of legislation permitting "emergency involuntary hospitalization of the mentally ill or suspected mentally ill with good cause shown" during the 1967 session of the Florida Legislature be approved.

Nurses Training Program

Recommendation by the Council on Allied Professions that the FMA encourage approval by the National League of Nursing of the junior college curriculum for the nurses training program in order that accreditation be established for these junior college programs through the National League of Nursing Accreditation Board.

Para-Medical Education

Recommendation by the Council on Allied Professions that the FMA take the initiative in establishing education standards of all paramedical personnel and that these standards be instituted in the vocational schools and junior and senior colleges.

Meetings

May

19-21 "Psychiatry and Neurology: A Practical Approach," Mound Park Hospital Auditorium, St. Petersburg.

September

16-17 Otolaryngology Seminar, University of Florida, Gainesville.

22-24 Cardiovascular Seminar, University of Florida, Gainesville.

October

20-22 "Industrial Medicine, The Doctors Role in Occupational Health," Mound Park Hospital Auditorium, St. Petersburg.

27-29 Neurology-Neurosurgery Seminar, University of Florida, Gainesville.

November

10-12 Pediatric Seminar, University of Florida, Gainesville.

17-18 Obstetrics and Gynecology Seminar, University of Florida, Gainesville.

Council and Committee Meetings

Editor's Note: The following are summaries of recent council and committee meetings. Final determinations on all actions or recommendations will be made by the Association's House of Delegates at the Annual Meeting in May.

T.M.

Council on Voluntary Health Agencies

The Council met January 22. It was noted approval was given the Council's recommendation authorizing officially recognized voluntary health agencies to use the following statement: "OFFICIALLY RECOGNIZED BY THE COUNCIL ON VOLUNTARY HEALTH AGENCIES OF THE FLORIDA MEDICAL ASSOCIATION."

The chairman and other members of the Council who participated in the 1965 Institute for Florida Voluntary Health Agencies discussed their roles in the program and stated this was an excellent and worthwhile Institute, worthy of further support.

Following study of its application, it was recommended official recognition be extended the National Multiple Sclerosis Society.

A joint meeting with executives of recognized agencies was held. Executive directors and representatives discussed current and future problems of their agencies. Agencies represented were: United Cerebral Palsy of Florida, Florida Tuberculosis & Respiratory Disease Association, National Foundation, Florida Association for Mental Health, Florida Society for the Prevention of Blindness, Florida Society for Crippled Children and Adults, Florida Heart Association, Florida Chapter of the Arthritis Foundation and the Florida Association for Retarded Children.

In order to stimulate greater physician interest in local voluntary health agencies, a motion was passed that local county medical society voluntary health agency committees should continue to be encouraged to establish their own criteria and to recognized those local groups considered worthy.

The Florida Voluntary Health Agencies Coordinating Committee advised that Mr. John Baird of United Cerebral Palsy of Florida has been appointed chairman for the 1966 Institute for Voluntary Health Agencies and that tentative plans have been made to hold the meeting August 18-20 at the Deauville Hotel, Miami Beach. Consideration has been given the possibility of expanding the Coordinating Committee scope by formalizing its organization.

The Coordinating Committee was requested by the Council to consider the possibility of establishing a joint accreditation mechanism for voluntary health agencies in order to preclude the threat of possible regulatory legislation.

Several suggestions were noted for the Council's proposed pamphlet for county medical societies which describes the Association's program and outlines suggested activities for voluntary health agency committees at the local level.

The chairman and staff were requested to explore the possibility of having a special issue of The Journal devoted to the voluntary health field.

It was suggested that a representative from United Health Foundations, Inc. be invited to attend the next meeting of the Council to provide information as to the organization's current activities.

As a result of a meeting initiated by the FMA to discuss the need for coordinating regional and state programs under the Heart Disease, Cancer and Stroke legislation, the Florida Advisory Council on Heart Disease, Cancer and Stroke has been formed. It will serve as a screening, coordinating and advisory body for local programs coming under this legislation.

It was discussed and decided that the Council should offer all possible aid to the Scientific Council in gathering and spreading information on postgraduate educational programs for physicians held in the state.

The Council discussed the possibility of inviting the chairmen of local county medical society voluntary health agency committees to attend future meetings of the Council to provide liaison, stimulation and encouragement to local committees.

It was decided the next meeting be held May 28 in Jacksonville.

Florida Joint Council on Health of the Aging

The Florida Joint Council met February 7. A general discussion was held concerning implementation of Public Law 89-97, Title XVIII A & B and Title XIX. Emphasized was the law's impact upon hospital, nursing home, medical and home care as furnished by the vendors of such care in Florida. No action was taken.

In considering the need for continuing the Council, the members felt the group had considerable potential as a forum for problems concerning Medicare and other matters common to the member organizations.

Motion was carried unanimously to continue the Florida Joint Council on Health of the Aging, and the next meeting was scheduled for May 23 at 10:00 a.m. in the FMA building. Member organizations of the FJC are Florida Hospital Association, Florida Nurses Association, Florida Nursing Home Association, Florida State Board of Health, Florida State Dental Society, Florida State Pharmaceutical Association, Florida State Department of Public Welfare, Licensed Practical Nurses Association of Florida and the FMA.

Committee on Aging

The Committee met February 6. Noted was the Board of Governors' acceptance of the Committee's recommendation that a proposed State Board of Health accident reporting program for nursing homes not be implemented.

A motion carried that the Committee favors continuing study of the problem of falls among older persons and encourages development of educational programs emphasizing the physician's office as an educational center.

Concern was expressed about some nursing home standards and the extent of state and local law enforcement. It was thought that the state agency responsible should increase inspection and provide certification for extent and types of care available in nursing homes.

The present and future need for the Florida Joint Council on Health of the Aging was discussed and it was concluded this Council should continue to serve as an open forum for common problems among the vendors of health care for the elderly.

Council on Medical Services

The Council met February 13. Individual Committee programs were considered and discussed and actions taken as follows:

Labor: It was noted that the present chairman recommended abolishment of the Committee. It was suggested that, among others, the problem of unionization of hospital employees needs attention. It was pointed out that the Committee should serve as a mechanism for organized labor to bring medical problems to the attention of the profession.

Aging: The Committee has recommended that a proposed State Board of Health accident reporting program for nursing homes not be implemented. It was suggested that the Woman's Auxiliary be encouraged to sponsor local home care programs.

Hearing: A general discussion was held of audiological screening in the public schools and related problems.

Child Health: A discussion was held concerning the implementation of Project Head Start in local areas.

Mental Retardation: A discussion was held concerning proposed legislation for mandatory PKU testing. A motion that diagnosis and treatment of diseases remain in medical hands and any future state legislation in this regard be opposed was defeated.

Maternal Health: The Committee plans to revise its maternal mortality survey questionnaire and classification forms. It was noted that some county medical societies have no committee on maternal health. A motion carried to recommend the introduction of a revised abortion law to the 1967 session of the Florida legislature, and that the model abortion law of the American Bar Association, approved by the AMA, be used in the preparation of such a bill. Motion carried recommending revision of hospital sterilization regulations. Motion carried endorsing the "13 county" Northeast Florida maternal health project. Motion carried that a pathologist be added to the Committee in an ex-officio capacity.

Emergency Medical Service: The view was expressed that emergency communications in the state are satisfactory. It was pointed out that in the committee's role as Medical Advisory Com-

mittee to the Selective Service System, only appealed cases come to the Committee's attention.

Public Health: Motion carried that public schools be urged to limit food and drink available to pupils on the campus to the Type A lunch, milk and full strength fruit juices, that nutritionally adequate food be provided in all schools and that the school curriculum emphasize nutrition education. Motion carried that counties now having venereal disease education in the schools be encouraged to continue and counties not having such education be urged to adopt it, and that county medical societies be urged to initiate VD educational programs for their members and local teachers. Motion carried to recommend introduction of a bill at the 1967 session of the Florida legislature establishing a statewide pasteurization law outlawing raw milk sale. Motion carried that the State Tuberculosis Board withhold any decision to close a tuberculosis hospital. Motion carried that approval be given addition of measles vaccine for indigents only to the State Board of Health immunization program under existing FMA policies. Motion carried that support be given voluntary PKU testing.

Mental Health: Consensus of the Council was that further construction of state mental hospitals be confined to metropolitan areas near medical centers. Motion carried that the FMA oppose establishment of a state mental hospital in Hernando County. Motion carried that legislation permitting emergency involuntary hospitalization of the mentally ill or suspected mentally ill with good cause shown be re-enacted during the 1967 session of the Florida legislature.

Rural Health: Descriptions of the 1965 AMA National Conference on Rural Health and plans for the 1966 conference were presented.

Indigent Care: Opinions were expressed that a proposal from the Florida Chapter of the Flying Physicians Association for rendering statewide medical services should include emergency situations as well as indigent aspects.

Blood: It was reported the blood insurance problem has apparently been settled. Other problems were discussed concerning blood collection for charitable overseas use and Red Cross blood banking programs. It was suggested that county medical societies should be advised that FMA's Committee on Blood is available to assist with local problems.

Vision: The apparent inaction of the Committee on Vision was noted and it was decided this information be communicated to appropriate FMA officers.

Council on Allied Professions and Vocations

The Council met February 13. Individual committee reports were heard as follows:

Dentistry: Items requested published in one of the "Briefs" are in suspense and will be published as soon as possible. No articles have been yet received from members of the Florida State Dental Society for submission to The Journal.

Medical Assistants: In the chairman's opinion, this is such a varied group that only proper recognition and individualized specialty education programs can begin to lessen their problems. The new junior college "Doctor's Assistants" program is felt one solution, and the medical assistants ask the FMA's support of this program.

Medical Technology: From three previous meetings have resulted basic principles the Committee believes are guidelines for revising the Florida law on medical technology. These principles are as follows:

1. That the law be under supervision and control of the Board of Medical Examiners.

2. That licensing of laboratories and personnel be under the same law and be administered by the State Board of Health under the direction of the BME.

3. That requirements for laboratory and personnel licensing conform closely to HEW standards.

4. That implementation be adequately budgeted for proper supervision with no prohibitive registrant's fees.

5. That proper supervision of laboratories under this law shall include annual license renewal and a formal inspection at least every three years.

6. That the law will not provide for medical technology school accreditation; the State Board of Education shall be encouraged to provide adequate medical technology education facilities; the BME shall determine minimum standards for examination admission.

Nursing: The Committee has studied a survey of "Nursing Needs" sponsored by the Texas Hospital Association and thinks Florida needs a similar study. Since there is great shortage of nurses and since such a survey does involve the entire state, the chairman has approached the State Board of Health in hopes of obtaining state financing. The FMA Board of Governors has approved such a survey in principle, but does not have the funds; so outside financing is necessary. In a meeting of the Committee and the Florida Nurses Association the following three problems were brought out by the FNA:

1. The prerequisites for admission to a Manpower Development Training program for nurses aides in Panama City are a low academic average, emotional instability or physical disability. The FNA and the Committee do not believe that these should be qualifications of someone going into homes of the elderly to provide care and it was suggested that this program be brought to the attention of the FMA for investigation.

2. No one is willing, on a local level, to approve the curriculum of the Junior College Nurses Training Program. The National League for Nursing will take this responsibility if asked. The FNA and the League believe they need the FMA's support in establishing accreditation for these programs.

3. Nurses feel their salaries should at least meet that of teachers. Unions have been suggested by some as a solution. The FNA and the Committee believe something needs to be done promptly about nurses' salaries.

From reports of the Committees on Medical Technology, Medical Assistants and Nursing, it was obvious that need exists for more "Para Medical" training groups. The way they are being trained now substitutes sub-standard technicians for trained nurses.

Veterinary Medicine: New suture materials were utilized on both human and animal subjects, the results to be published later. Electron microscope studies of nerve tissue tumors and genetic involvement in some congenital defects are projects in early stages. Preliminary lymphatic anatomy studies of last year are now being used for clinical follow-up experiments.

X-Ray: There has been some discussion of an X-Ray Technician Law.

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Woman's Auxiliary
The New Look — 1966

In his excellent "Critique of the Florida Medical Association 1965 Annual Meeting" published in The Journal, Dr. Walter Glenn issued a challenge to the Auxiliary when he said, "We are in need of new ideas in the Auxiliary and in the Association that will interest more members from the nondelegate portion of our membership." For the past year we have been giving serious thought to the content of our next State Convention of the Woman's Auxiliary and we believe we have come up with some wonderful innovations that will stimulate the interest and spark the vigor of the members. So please encourage your wives to come this year and tell them that many surprises await them.

First of all, they will not want to miss the Presidents' Tea and Fashion Show on Thursday, May 12 at 2:30 p.m. This will be a seated tea with goodies to eat and styles such as you have never seen before. Cleverly presented reports from the various counties showing their most outstanding progress during the year will be illustrated by our fashion models. Awards and door prizes will be a part of the program.

This tea will honor all of our Presidents—past and present, state, county and national. Yes, we are going to have our national President with us at Convention this year. All Presidents are asked to invite their fans to come along with them and these admirers will be seated near them; thus each President will have her own fan-club.

On Friday morning, May 13, at 9:30 a.m., the House of Delegates will have a NEW LOOK, too. Voting procedures will be simplified, and with county Presidents' reports moved to another day, more time will be allowed for delving deeper into other aspects of Auxiliary work. The Memorial Service will be at the beginning of the meeting and members will be invited to "Go Down Memory Lane" in honor of our deceased members. Also, we will have the rare opportunity to hear a message of inspiration from our national President.

The luncheon on Friday is a "Partnership Buffet" to which husbands are most heartily invited to come with their wives. Our partner will be FLAMPAC and all officers and members of that group will join us bringing their speaker, former Governor and now Supreme Court Justice Millard Caldwell. This will be an informal luncheon, without the usual ceremony, so that if you are pressed for time you may be able to enjoy your meal and hear the speaker, too.

Even the Post Convention Board Meeting has a new look. In place of the uncertain School of Instruction will be a "Roving Question and Answer Period." Each past committee chairman and the incoming chairman will have a table and display of materials where Auxiliary members and county chairmen will have an opportunity to rove from table to table—to ask questions and pick up material on the subject of her choice. This will take place for an hour and will be followed by a short and snappy Board of Directors Meeting in the same room.

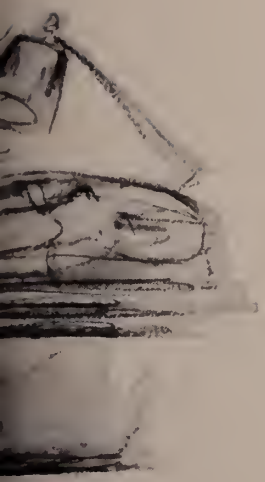
Friday evening we will all meet at the FMA President's Reception and I am sure we will all feel a glow of accomplishment and a tinge of pleasure at having had a good meeting.

But there are still good things to come! While our doctors are attending the specialty meetings Saturday morning, we will bus over to the Diplomat Country Club for a Public Speaking Seminar, conducted by the Speech Training Department of Smith, Kline and French. This will be open to both doctors and wives and is a real opportunity to learn some fine points of Public Speaking. There is no admission charge.

There is something in this program for everyone and we hope that the Florida Medical Association will be proud of the Woman's Auxiliary.

Mrs. Russell B. Carson,
Convention Chairman
Woman's Auxiliary to the
Florida Medical Association





So when my neighbor told me about these marvelous yellow pills *she's* taking, I decided to come right down and get the same thing from you.

any luck, you'll convince her that there are y kinds of little, round yellow pills and that aren't always meant to relieve acute sinusitis. might tell her instead that you've got just the g—pink, capsule-shaped tablets: Novahistine let.

single tablet provides prompt analgesic effect elief of sinusitis pain. Novahistine Singlet attacks the underlying cause of the head- —helping to open blocked respiratory pas- s and restore normal breathing and sinus age. The continuous decongestant effect uced by taking one Novahistine Singlet every 8 hours reduces the chance of acute sinusitis progressing to chronic stages.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Tell ambulatory patients that Novahistine may occasionally cause drowsiness. Each tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

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For the relief of sinusitis pain and congestion.

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Deaths

Black, M. Eldridge, Clearwater; born in Banks, Ala., Oct. 7, 1900; Tulane University School of Medicine, New Orleans, 1922; interned at Charity Hospital of New Orleans; practiced in Tuscaloosa, Ala., 1923-1926; had engaged in the practice of general surgery and gynecology in Clearwater since 1926; was a former vice president and president of the Pinellas County Medical Society; was a life member and in 1949 served as Second Vice President of the Florida Medical Association; represented his county medical society in the House of Delegates of the Association from 1947 through 1958; held membership in the American Medical Association, Southeastern Surgical Congress, International College of Surgeons and Florida Association of General Surgeons; died February 17, following a cerebral accident, aged 65.

Bradshaw, Virgil Marlow, Tampa; born in St. Louis, Mo., June 30, 1901; St. Louis University School of Medicine, 1928 to 1931, and received his M.D. degree from Rush Medical College, Chicago, 1933; interned at Tampa Municipal Hospital, 1933-1934; served a residency at St. Joseph's Hospital, Tampa, 1934-1935, engaged in the general practice of medicine in Tampa, 1935-1952; suffered severe injuries in two accidents which forced him to terminate his practice in 1952; died Dec. 4, 1965, following rupture of an aneurysm of the thoracic aorta, aged 65.

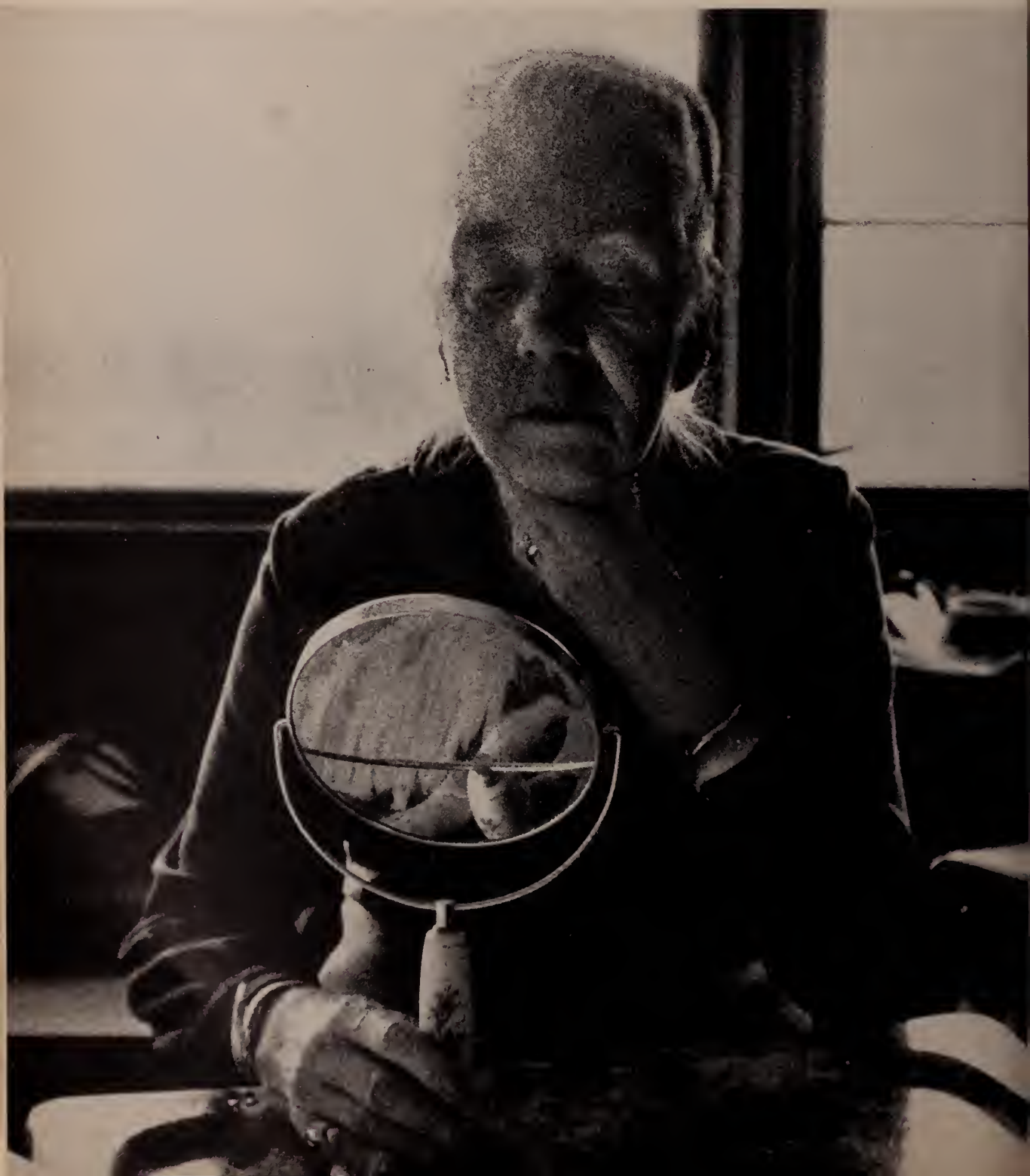
Field, Roddy Allen III, Orlando; born in Newnan, Ga., Nov. 17, 1931; Emory University School of Medicine, Atlanta, Ga., 1957; served an internship and a residency in Greenville General Hospital, Greenville, S.C., 1957-1959; served a residency in obstetrics and gynecology at Orange Memorial Hospital, Orlando, 1959-1961; entered the private practice of his specialty in Orlando in 1963; was in the Medical Corps of the U.S. Air Force, 1961-1963, serving with the rank of captain; held membership in the American Medical Association, American College of Obstetrics and Gynecology and American College of Surgeons; died January 24, aged 34.

White, Joseph William, Fort Lauderdale; born in Scranton, Pa., May 12, 1897; Jefferson Medical College, Philadelphia, Pa., 1926; interned at Atlantic City General Hospital and engaged in extensive postgraduate study at the University of Pennsylvania and the University of Vienna, Austria; practiced general surgery in Scranton for 29 years before coming to Fort Lauderdale in 1958; was a veteran of both World Wars, retiring from the service in 1946 with the rank of lieutenant colonel in the Army Medical Corps; engaged in a wide range of professional activities in his native state from 1928 to 1957; was distinguished for his research on cancer and was the first area physician to use radium in the treatment of this disease; received the 15 year national award of the American Cancer Society in 1957; was a frequent contributor to medical literature; was a member of the American Medical Association, American Society of Abdominal Surgeons, American Radium Society, American Medical Writers Association, a fellow of the American College of Surgeons and of the International College of Surgeons, a diplomate of the American Board of Surgery, and a life member of the American Medical Society of Vienna; died June 20, 1965, in Atlantic City, N.J., aged 68.

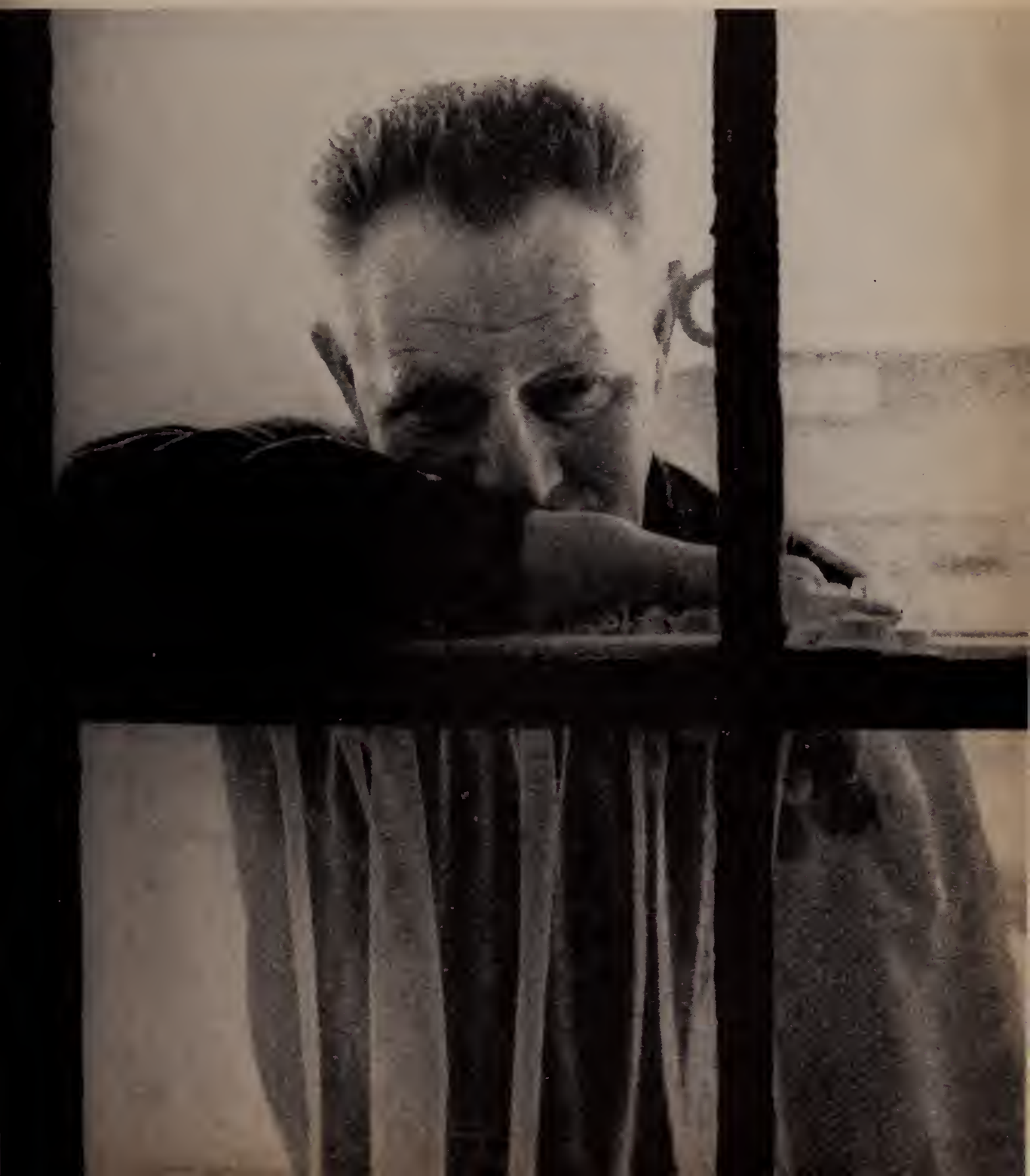
The Mediatric Age:
There is a growing senescent body of people who –either from lack of motivation, or as a result of surgery, trauma, or extended illness– are on their way to malignant inactivity...



The Mediatric Age:
Some may be not quite sick, nor yet quite well. They may complain of too easy fatigue, of vague aches and pains.
Many need your assurance that they are not as old as they feel...

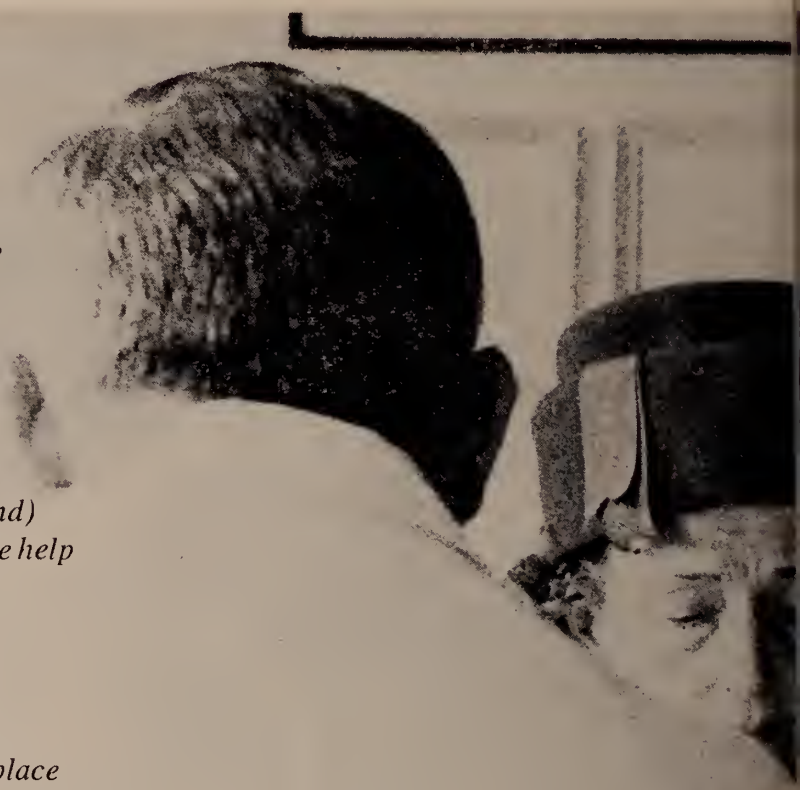


The Mediatric Age:
Frequently, they become "the waste-aways."
They have simply lost interest in
the maintenance of their own well-being—
often through the feeling
that they are no longer needed.



The Mediatric Age:

Unfortunately, there is no cure. But there are, largely through your own interest and direction, ways to help them back to a more active and useful life. There are medicines, too, designed to help. One such has proved useful in clinical practice:



"A steroid-nutritional compound (Mediatric) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging . . . This therapy resulted in improvement of 75 per cent of the patients . . ."

McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

"Mediatric (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

Morgan, A. F.: Gerontologist 2:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied . . . The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist 2:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.

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Designed for the "metabolically spent"

Nutritional reinforcement for those who can't – or won't – eat properly...balanced amounts of estrogen and androgen to counteract declining gonadal hormone secretion and its sequelae of premature degenerative changes...mild antidepressant for a gentle "mood" uplift...

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens—equine), the natural estrogen most widely prescribed for its superior physiologic and metabolic benefits.

MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation*. It contributes a *gentle "mood" uplift* through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

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Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
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Ferrous sulfate exsic.	30.0 mg.
Methamphetamine HCl	1.0 mg.

Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

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Each chewable tablet contains:
nicotinic acid (niacin) 75 mg. and
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Administration and Dosage: One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

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overcomes guilt, lifts depression, restores confidence

Feelings of guilt, worthlessness, emptiness and loss frequently characterize depression. Such feelings, along with insomnia, physical complaints, sadness, apprehension, and other symptoms of depression rapidly respond to Norpramin (desipramine hydrochloride). Improvement often begins in 2-5 days, sometimes in less. A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Side effects, usually mild may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

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In serving you, the Guild Optician also has a stake in the welfare of your patients; depend on his expert services and experience to be sure your patients are getting the best possible results from the prescriptions you write! *Guild of Prescription Opticians of Florida.*

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"Everything I eat turns to FAT!"

For the patient who must lose more than 15, 25 or even 50 pounds

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For the patient who must lose more than 15, 25 or even 50 pounds...

the patient who must adhere to a long-term regimen—mere appetite suppressants are often not broad enough in scope. They suppress appetite and help achieve minor weight loss, but after several weeks the patient frequently becomes discouraged by a weight plateau. Many times other problems such as anxiety, constipation and hunger spasm complicate therapy.

Phantos Day-Long Action Capsules afford more complete obesity control because one capsule daily provides much more than mere appetite suppression. In addition to day-long appetite control, Phantos capsules supply a mild metabolic boost, alleviate hunger spasm, provide general mild laxation and promote sound sleep.

Unlike ordinary anorectics, the Phantos formula anticipates the problems which demoralize the dieting patient. The components are released at different times throughout the day, thus adhering to the changing pattern of the patient's need.

Each Phantos Day-Long Action Capsule supplies: for immediate release—amphetamine sulfate 5 mg., thyroid ½ gr., atropine sulfate 1/360 gr., aloin ¼ gr.; for intermediate release—amphetamine sulfate 5 mg., thyroid ½ gr., atropine sulfate 1/360 gr.; for final release—amphetamine sulfate 5 mg., thyroid ½ gr., phenobarbital* ¼ gr.
Also, Phantos-10: two-thirds above formula.

Dosage: One Phantos capsule daily, taken before breakfast.

Precautions: Contraindicated in cases of marked hypertension, coronary or cardiovascular disease, diabetes mellitus and thyroid disease. Use with caution in patients hypersensitive to barbiturates or sympathomimetic compounds (*Warning: May be habit-forming).

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anticipate the problems which demoralize the dieting patient

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Please send me a sample supply of **Phantos®** *Day-Long Action Capsules*

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Obstetrical or post—surgical patients requiring a dependable increase in hemoglobin will receive as much iron (250 mg. in a 5 cc. ampul) as in one pint of blood. Imferon (iron dextran injection) is less expensive and it avoids the well-recognized hazards of whole blood transfusion. When patients cannot—or cannot be relied upon to—take oral iron, Imferon (iron dextran injection) will rapidly supply needed iron for reserve stores.

ONE PINT OF BLOOD PROVIDES NO MORE IRON THAN ONE 5 CC. AMPUL OF



IMFERON®
(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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"The main function of the carotid sinus is regulation of the blood pressure...."[1]

The veratrum component of Salutensin acts here (and in the myocardium), initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."[2]



SCHWENK

This is a logical Blood Pressure Regulator

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OR REDUCING
LOOD PRESSURE

In mild to moderate hypertension:

Salutensin enhances the body's own mechanisms for lowering blood pressure. The veratrum component of Salutensin acts on the carotid sinus and myocardial receptors, initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."[2] To achieve this reflex modification of hypertension, Salutensin utilizes protoveratrine A. In addition, to facilitate and maintain blood pressure reduction, Salutensin incorporates reserpine and a highly effective thiazide. In general, side effects have been reported infrequently but may include those listed in the therapeutic summary.

Simple dosage—low-cost therapy: Many patients on Salutensin respond to 1 tablet *b.i.d.* Long-term economy is assured, since dosage can frequently be lowered after initial control is established.

Available: Prescription-size bottles of 60 tablets.

References: 1. Editorial: JAMA *191*:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: Hypertension, Philadelphia, W.B. Saunders Company, 1959, p. 395.

BRISTOL THERAPEUTIC SUMMARY
For complete information consult Official Package Circular.
Indications: Essential hypertension.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs.
Contraindications: Salutensin is contraindicated in severe depression.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).
Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
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Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

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1. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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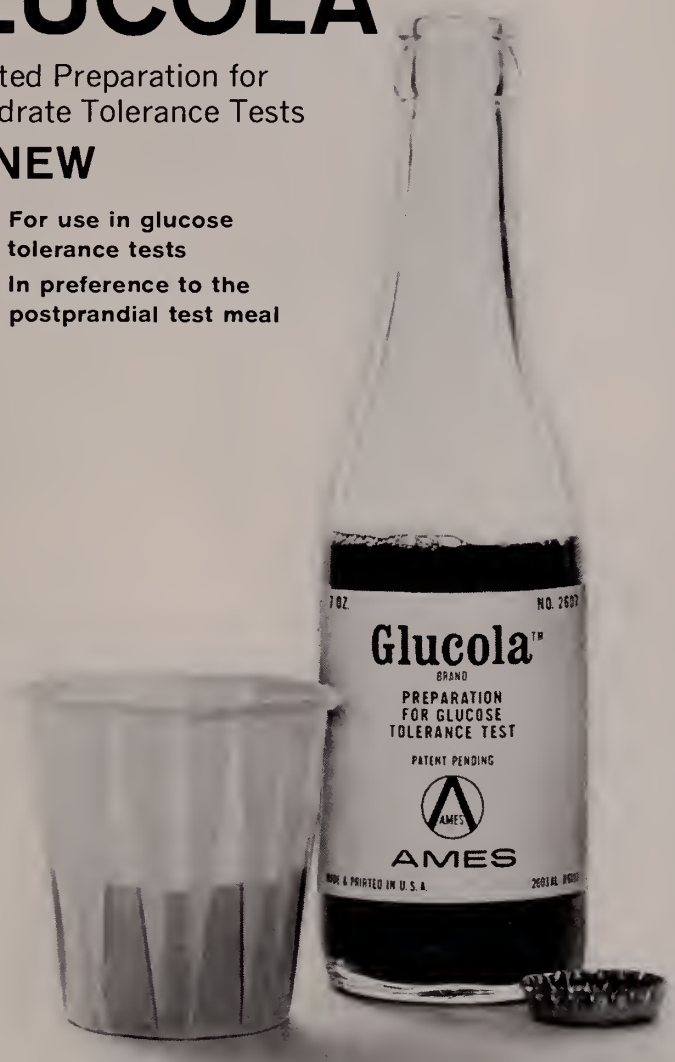
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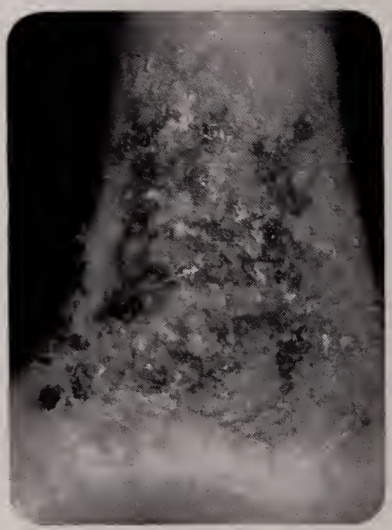
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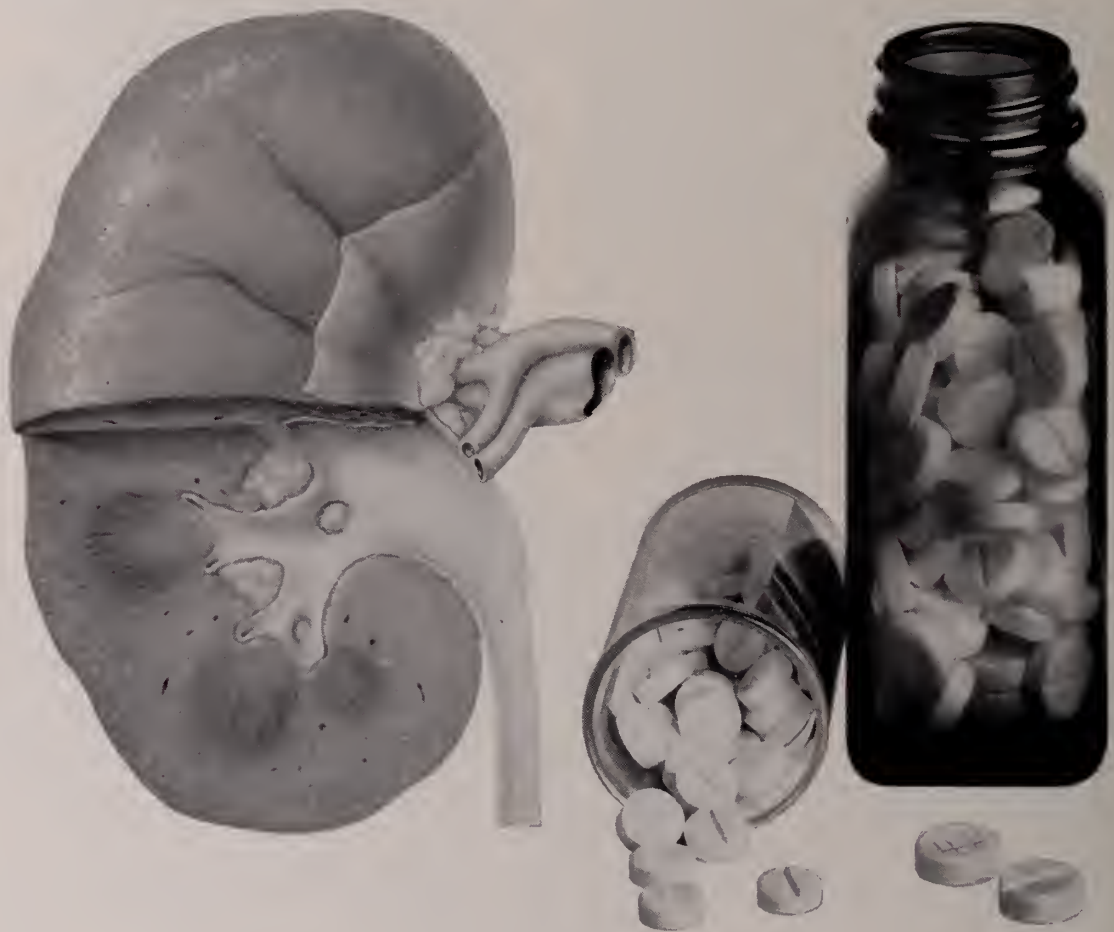
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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

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Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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The JOURNAL
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The Public Health Physician And The Private Practitioner

JOHN D. MILTON, M.D.*

Physicians devoting themselves to private practice and those engaged in the discipline of public health are all men of Medicine. They received their education and training in the same schools and institutions; their respective fields of service were selected by choice. Their outlook upon their work, its ultimate value and life in general conforms with their manner of practice, and this is understandable. Yet, when the separation of special interests is such that public health and private physicians do not consider themselves co-workers in one of the noblest of professions, it is time for critical re-examination of their differences in the light of pronouncements by the leaders in Medicine.

In a comparison of the two fields of service—private practice and public health—the reason for the divergent point of view is obvious; however, upon examination the fundamental differences are not so well defined. The physician in private practice is on a one-to-one relationship, or person-to-person. The public health physician is on a one-to-many relationship; he deals with the group: his patient is the organized community with its structure of units and departments, voluntary health organizations and paramedical groups headed most frequently by persons who are considered laymen in matters of medical policy. The public health physician often is necessarily connected with and considered a part of a political organization; however, in recent years the physician in private practice also has entered into a somewhat similar position.

See editorial comment page 517

Nevertheless, both are physicians with abilities which are necessary to their chosen specialties in the fields of medicine and health. It is, therefore, incumbent upon each to strive continuously for a sound relationship between their particular special interest groups.

Philosophy of National Organizations

The American Medical Association for many years has conducted studies into the problems associated with public health. Statements regarding possible solutions were formulated and adopted in 1948 and in 1950. In 1956, the Board of Trustees requested the Council on Medical Services to undertake two studies:

Read before the Florida Public Health Association, Health Officers' Section, 37th Annual Meeting, Clearwater, Oct. 8, 1965.
*Past President, Florida Medical Association and Florida State Board of Health.

1. An evaluation of the relationship of physicians not in private practice to those in private practice; and

2. A study aimed at evaluating the growth and present status of public health in relation to the private practice of medicine.

The first part of the study was aimed at strengthening the American Medical Association as an organization for all doctors of medicine including those engaged in public health activities. A report was approved by the Board of Trustees and referred to the House of Delegates in December 1960. It was adopted by the House in 1962. The second part is yet being considered.

The recommendations as adopted by the House of Delegates regarding the first part included:

> That the policy statement on public health services of the American Medical Association be as follows:
> Public health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts. It includes those arrangements whereby the community provides medical services for special groups of persons and is concerned with prevention or control of disease, with persons requiring hospitalization to protect the community, and with the medically indigent.

In 1950, the House adopted a report on the general subject of public health departments, their administration and functions, and in it consideration was given to the so-called basic six services:

> . . . In the opinion of our committee, it is the desire of the House of Delegates to reaffirm its long-established approval of the extension of public health activities for the protection of the people and only when necessary, to accept federal aid for this purpose. In expressing this opinion, your committee wishes to reemphasize that the services of departments of public health should be limited to (1) vital statistics; (2) public health education; (3) environmental sanitation; (4) public health laboratories; (5) prevention and control of communicable diseases, and (6) hygiene of maternity, infancy and childhood, if private facilities are unavailable. . . .

In November 1963, the "new basic six" guides for public health agencies were discussed by Dr. Luther L. Terry, Surgeon General of the U. S. Public Health Service, at the 91st Annual Meeting of the American Public Health Association in Kansas City. These were outlined by Dr. Terry as:

1. Health maintenance activities for the community and the people in it against diseases or conditions caused by infectious agents, metabolic changes, genetic factors, emotional disorders, or environmental influences;

2. Continuous assessment of the ecology and resources of the community as they relate to health;

3. Leadership in planning for effective community health services and participation in providing organized patient care services for both episodic and long term illnesses;

4. Study of man's environment and appropriate action to reduce or eliminate hazards to health and to provide safe and pleasant surroundings;

5. Support and conduct research aimed at new health knowledge and its efficient application to those who can benefit from it;

6. Partnership in policy determination and decision-making so that health is given rightful consideration in all activities of society.

After careful reading of the report of the Council on Medical Services and recommendations as adopted by the House of Delegates of the American Medical Association, the previously approved report on administration and functions of public health departments, and Dr. Terry's complete address, it appears that there is little basic difference in the opinions of the two national organizations.

Statement of Florida Medical Association

In 1958, a Liaison Committee to the State Board of Health was appointed by the Florida Medical Association, and at the Annual Meeting in April 1960, this Committee reported to the House of Delegates:

> The committee feels that relations between the State Board of Health and the members of the Florida Medical Association are excellent. Points of friction are at a minimum. The Board of Health is very cooperative.
> The committee would like to stress and encourage close liaison between component county societies and their own local health departments. It is the committee's feeling that almost all points of friction can be resolved in advance with this type of cooperation.

Individual Relationships

The relationship between the private practitioner and the public health physician has not always been cordial; yet, there has been considerable improvement since 1925 and 1926. In an editorial in the November 1963 Virginia Medical Monthly, Dr. John T. T. Hundley of Lynchburg, Va., stated that ". . . there is yet a residual of resentment and jealousy, and a feeling of unjusti-

fied competition between the private physician and public health directors. It can be eliminated, and will be when each realizes the need of the other, that they cannot work effectively alone, and can be mutually helpful."

A concentrated and cooperative effort by the two special interest groups provided a hopeful approach and the two disciplines came to the realization that they did indeed need each other. The distance of the separation was not too great; fundamentally, the similarity of the individuals had been a preventive agent. Dr. T. Paul Haney, one of Florida's health officers, could have been addressing all physicians with candor when he stated at the 1962 Annual Meeting of the American Public Health Association in discussing "The Health Officers' Code" that characteristics of the health officer should be honesty, sincerity, courage, confidence, vision and dedication.

Within Florida the relationship between the individual physicians in private practice and in public health varies greatly with the size of the particular community and how well the people are endeared to the organized medical group or to certain groups in the medical society. It also depends upon how well the residents of the community like the local health department and the influence it has upon the people.

As measured by these criteria, the actions—and the thinking—of the physicians in any Florida community are among the best in the country. This relationship is obvious to those who attend regional and national meetings. Here the private practitioners of medicine and surgery and the health officers can be heard loudly and clearly, and the organizations feel extremely fortunate in having these men speak up for Florida medicine and public health.

The general realization and appreciation of the fact that the cooperative and cosponsored programs of the organizations of public health physicians and private practitioners have been of real value in the large metropolitan centers such as New York, Boston, Philadelphia, Chicago and San Francisco, cannot be readily transferred to Florida. Circumstances in this state do not warrant the duplication of similar agreements between the members of the small county medical society and the county health officer; however, in the centers of population these programs serve well the purpose for which they were established.

Personal Considerations

In professional organizations, whether the physicians practice in public health or one of the other specialties, they feel the common bond of being a part of Medicine; yet as individuals in their own practice locations, some tend to forget the dignity which should be a part of their own activities and delight in "taking a dig" at their colleagues. There always will be a few in each discipline who close their minds to the value of the accomplishments of others in their community. This is a human failing and will exist wherever men work together, or separately, in attempting to reach a common goal. The great majority of health officers and private practitioners, however, will continue to cooperate in an atmosphere of good will and appreciation of one for the other.

Several basic considerations might be of value in strengthening the relationship between those of each group:

1. Both the health officer and the private practitioner are a part of Medicine and should never consider themselves as outsiders. Each should have an appreciation of this fact and never let his own attitude shut out his colleague. Neither interrupts the work of Medicine.

2. Organized Medicine is not doing the private practitioner or health officer a favor. It is the job of each discipline to add to and round out its full ramifications.

3. Private practitioners realize that the health officer deals in more than "cold" statistics and is more than a "number." His feelings and emotions are the same as those of any other physician and his need for the companionship of his colleagues is just as strong.

4. Health officers or physicians engaged in other specialties should not endeavor to match wits with one another because each group is deserving of the same dignified and courteous attention.

5. The individual physicians and the health officers alike are not absolutely dependent upon Organized Medicine but they should be mindful of its value. Each can benefit in direct proportion to the time he devotes to the county, state, regional or national societies. All physicians should consider themselves integral cogs in the functioning of each dynamic organization.

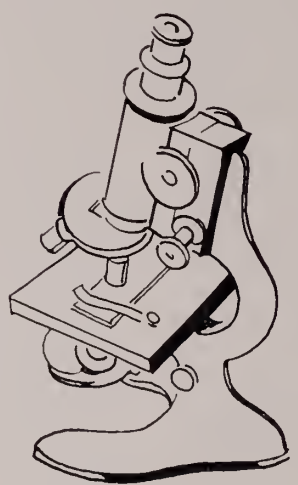
6. The health officer has his problems in the community and should bring them to the appropriate committee of the local medical society so that they may be fully evaluated. The committee members should remember that the health officer is thinking primarily of preventive medicine, not treatment, and render a decision which they believe will be of greatest benefit to the community.

7. Health officers are responsible for sanitation in the community, control of the infectious and communicable diseases and other types of preventive medicine and therefore should be able to call upon the private practitioners for assistance whenever needed.

8. As the protectors of child health, the health officer and his colleague in private practice should be alert to the provision of adequate prenatal, natal and postnatal care in the knowledge that the care will result in healthier mothers and children.

9. The private practitioner and the health officer should walk erect, proud but humble, knowing full well that both are a part of Medicine, fraternizing with their colleagues in an effort to cement good professional relations.

▶ Dr. Milton, 266 Palermo Avenue, Coral Gables 33134.



Eosinophilic Granuloma Of the Stomach

CHARLES A. MONNIN JR., M.D.

Eosinophilic granuloma of the gastrointestinal tract was first mentioned in the medical literature in 1937 when Kayser published a report of three cases. In 1961, Ureles culled the literature up to that time and found 25 cases of diffuse eosinophilic gastroenteritis reported; he referred to these as "Class 1." He also summarized 22 cases of circumscribed eosinophilic infiltrative granuloma, designating them as "Class 2." This condition, therefore, has been relatively unrecognized. The importance of the Class 2 cases is that they are frequently confused with carcinoma of the stomach, presenting clinical and roentgenographic signs of atypical pyloric obstruction. In the case reported here a preoperative diagnosis of eosinophilic granuloma could not be made. Actually, as has been substantiated by previous cases described in the literature, only in patients of Class 1 is eosinophilia demonstrable in the peripheral blood.

Of the many conjectures as to what will initiate this "eosinophilic gastroenteritis" or "eosinophilic granuloma," three have been emphasized: (1) hematogenous allergens, (2) local gastrointestinal allergens, and (3) foreign body reactions. The provisional classification as originally described by Ureles seems the most appropriate. He and his group referred to Class 1 as a diffuse eosinophilic gastroenteritis characterized by extensive thickening and induration of the antrum extending throughout the jejunum and ileum. The findings showed a great similarity to those of gastroenteritis. In some cases the involved areas were firm, feeling like cartilage, especially in the distal end of the stomach. The pylorus was hypertrophied and narrow. Other areas of the gastrointestinal tract were in some instances vascular and edematous and the mesentery was inflamed, boggy or fibrotic. Hyperplastic lymph nodes were in evidence and even ascites was reported. The serosa may appear reddened with yellow or grey patches.

Microscopically, a diffuse chronic inflammatory infiltrate frequently extended from the mucosa up to, and at times including, the serosa. This finding was dominated by sheets of mature polymorphonuclear eosinophils which infiltrated the bundles of the muscularis and the periarterial connective tissue. Less often, macrophages or giant cells were noted. The edematous areas consisted of a proteinaceous coagulum. Muscle areas at times appeared necrotic, with varying degrees of hyalinization or replacement fibrosis. True hypertrophy of the muscularis propria was common; hyperplasia was only occasionally seen. The muscosa was notably free of involvement except for a rare superficial erosion. There was nothing to suggest a granuloma.

In this series, the predominant age range of Class 1 was the second to the fifth decades. Principal symptoms were intermittent episodes of severe nausea, vomiting, flatulence, and diarrhea with epigastric cramps and heartburn not relieved

by antacids. Approximately 50% of this group had either an allergic history or symptoms suggestive of an allergic history.

In some cases x-rays showed a smooth concentric narrowing of the gastric antrum suggesting either an extrinsic mass or an infiltrating carcinoma. Sometimes a tubular segmental narrowing of the small bowel interspersed with dilated loops was demonstrated. Most of the patients in this group were subjected to subtotal gastrectomy.

In Class 2 of Ureles there were 22 patients. "Microscopically, the picture was one of a granuloma abundant in reticular and fibroblastic proliferating elements, histiocytes, and newly formed blood vessels. Lymphocytes and plasma cells were common. The outstanding feature, of course, was the massive infiltration of mature eosinophiles throughout the lesion. These eosinophiles split the muscularis mucosa and the muscularis propria. Peripheral eosinophilia usually are absent when only the antrum of the stomach is involved. There was customarily found a sharply defined filling defect. This finding was usually misleading in that a presumptive diagnosis of gastric ulcer and/or gastric carcinoma was usually made."

Report of Case

A 53 year old white woman was admitted to the South Miami Hospital on Oct. 27, 1964, in relatively acute distress. She gave a four week history of upper abdominal pain, nausea, vomiting, indigestion, and heartburn. These symptoms had failed to respond to several antacids and were frequently aggravated by taking solid foods so that for the most part she had limited her intake to liquids. This factor, combined with a long history of alcoholism, probably was responsible for the resulting loss in weight of 15 pounds. There was no history of constipation, diarrhea or melena. The patient had been troubled with cirrhosis. She said she was allergic to penicillin and sulfa drugs. The remainder of the history was irrelevant.

Physical examination revealed a somewhat thin white woman in moderate distress because of abdominal pain. There was some epigastric tenderness. No spasm and no masses could be made out. Laboratory studies of the urine revealed: pH 7.0, specific gravity 1.005, 20 to 25 white blood cells per high power field, acetone 3 plus, serum amylase 129 sigma units and fasting blood sugar 142 mg.%. The hematocrit level was 38%, hemoglobin estimation 12.9 Gm. and white blood cell count 3,600, with segmented forms 80%, lymphocytes 14%, monocytes 5% and eosinophils 3%. Three days later the eosinophils were 1 per cent. Prothrombin was 84% of normal, cephalin flocculation 2 plus and alkaline phosphatase 8 mg.%. Bilirubin was 0.6 mg.%, CO_2 combining power 263 mEq. per liter, serum chloride 92 mg.%, potassium 4.3 mEq. and sodium 135 mEq.

Chest x-rays demonstrated no active disease. Following oral administration of Telepaque the gallbladder concentrated only moderately. This fact was related to demonstrable gastric retention of contrast medium.

The gallbladder showed a normal silhouette with no evidence of stones. An upper gastrointestinal series was reported as follows: "At fluoroscopy the esophagus appeared normal. The films of the lower part of the esophagus suggest an inconstant defect compatible with a symmetrical sliding type hiatal hernia. The stomach has a normal position. The mucosa appears normal until reaching the antrum. There appears to be some infiltrative process on the posterior wall that is involving largely the posterior intramural portion of the stomach. The mucosa in this area is bizarre. In the center of this intramural defect is a 1 centimeter constant collection of barium which has the appearance of an ulcerative gastric lesion. A severe amount of pylorospasm prevented filling of the duodenal cap. When the cap is filled no cicatrix, niche or mucosal changes were demonstrated. The 'C-Loop' appears to be enlarged in general without any definite or specific indentation. Furthermore the duodenal sweep is displaced more anteriorly than usually noted on the lateral views. These findings are compatible with some diffuse enlargement about the head of the pancreas." The impression was: (1) The possibility of pancreatic malignancy with invasion into the posterior wall of the stomach and central ulceration. (2) Atherosclerosis of the abdominal aorta.

An upper gastrointestinal series two weeks later was reported as follows: "Re-evaluation of the upper gastrointestinal tract shows a marked amount of improvement without the findings previously reported, which were principally confined to the gastric antrum. The present findings now consist of a collection of barium within the antrum about 3 centimeters proximal to the pylorus which has some irregularity of the mucosa, but there has been a dramatic reduction in this circumscribing infiltration, most likely of edematous origin." The impression at this time was: (1) An active antral gastric ulcer with surrounding antrogastritis, and (2) Associated changes seen on the original view of the upper gastrointestinal tract showed considerable improvement.

A preoperative electrocardiogram was within normal limits.

On November 11, hemigastrectomy with antecolic gastrojejunostomy was performed. The gallbladder was soft and compressible and contained no stones. The pyloric region of the stomach was thickened by what was thought to represent an early gastric carcinoma. A wedge-shaped biopsy specimen was taken from the right lobe of the liver. A routine appendectomy was carried out. The patient did extremely well, and she was discharged improved on the fourteenth postoperative day.

The pathological report was as follows: "Grossly the stomach wall is thickened up to 1.2 centimeters and the mucosal pattern is prominent, but the folds are not quite of the 'giant type.' The folds are thickened and widened and elevated up to one centimeter. The pylorus is prominently hypertrophied and measures up to 1.5 by 1 cm. The pre-pyloric mucosa has an exaggeration of the normal follicular pattern. There is gradual tapering from the pylorus to the muscular layer of the stomach proper over a distance of approximately 4 centimeters before the muscularis of the stomach proper measures 0.3 centimeters.

"Microscopically, the pylorus shows marked hypertrophy of the smooth muscle bundles and a dense eosinophilic infiltrate in the interstices. The eosinophilic infiltrate is almost entirely pure, with occasional lymphocytes and plasma cells. The infiltrate is also present but to a lesser degree in the submucosa and the lamina propria. The epithelium of the pylorus is unremarkable. The serosa has fibrous thickening. The architectural pattern of the liver is preserved with orientation of cell cords about the central vein. There is disruption of the peripheral portion of the lobules by fibrous and inflammatory thickening of the portal tracts. There is sequestration of individual liver cells and clusters of liver cells within the portal tracts. There is minimal bile duct proliferation. The inflammatory infiltrate is of mixed type featuring predominantly

lymphocytes, but containing numerous polymorphonuclearcytes and eosinophiles. The liver cells show a moderate to severe fatty vacuolization with both types of Mallory hyaline identified, viz. spherical hyaline bodies and so-called alcholic hyaline of reticulated appearance. Bile stasis is not evident. The appendix is unremarkable. Diagnoses: (1) Gastritis with eosinophilic granuloma, pyloric hypertrophy with eosinophilic infiltration. (2) Portal Cirrhosis, fibro-fatty stage, active, consistent with nutritional (so-called alcoholic) type."

Summary

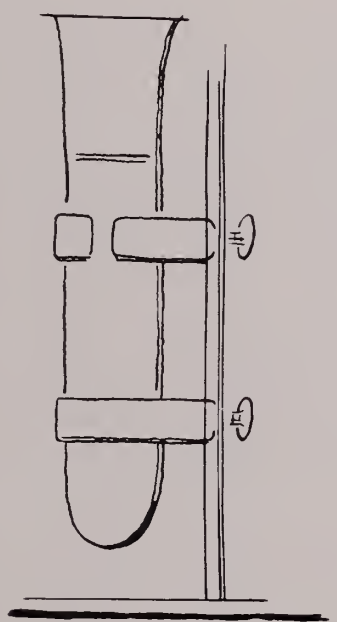
A typical case of eosinophilic granuloma of the stomach is reported. Preoperatively it was thought that the patient had an active antral ulcer with circumscribing antral gastritis.

At the time of operation a diagnosis of carcinoma of the antrum was entertained. As noted in other reported cases of eosinophilic granuloma of the stomach, no peripheral eosinophilia was present prior to operation.

The author gratefully acknowledges the contributions of Timothy A. Lamphier, M.D., who assisted with the surgery and helped prepare the paper, and William N. Haynes, M.D., the family physician who treated the patient before and after the hospital stay.

References are available from the author upon request.

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Pacemaker Problems

THOMAS D. BARTLEY, M.D. and MYRON W. WHEAT JR., M.D.*

The advent of electronic devices for continuous stimulation of ventricular contraction with pulse generators housed in packages small enough for implantation in the human body has been a life-saving development for many patients.[5,11] As with any new device, however, problems have arisen. This report deals with some of those problems and techniques we have used to avoid or solve them.

During the past three and one-half years at the University of Florida Hospital 38 implantable pacemakers have been inserted into 29 patients (table 1). Most of these were fixed rate pacemakers with electrodes made of twisted stainless steel electroplated with gold and platinum and insulated with Teflon.**

Patients with intermittent or complete heart block and a history of syncope are taken immediately upon admission to the radiology department for insertion of a right ventricular electrode which is attached to an external power source.[9] We have adopted this routine to prevent the occasional disastrous arrest that may occur while awaiting permanent pacemaker implantation. A fixed rate implantable pacemaker is inserted into those patients with complete heart block. Patients with intermittent heart block are presently being managed by implantation of the Atricor unit*** because it adapts better to the patients with varying block.[1] Attempts at management of patients with heart block and a history of syncopal episodes using isoproterenol hydrochloride (Isuprel), atropine and other drugs have been futile in the past in our experience and have served only to delay necessary surgery. In one patient this was a fatal delay.

Early in the series, the pulse generator package was housed in a pocket formed in the chest wall beneath the pectoralis major muscle superior to the thoracotomy incision used to attach the electrode wires to the myocardium. During the past two and one-half years, this package has been inserted in the abdominal wall beneath the external oblique aponeurosis or the rectus muscle. The electrode wires were attached to the lateral right ventricular or left ventricular myocardium through a short anterior or anterolateral incision through the bed of the resected fourth rib or the fourth interspace (fig. 1). Prophylactic antibiotics were given to about half of these patients.

The problems can be divided roughly into four major categories; pulse generator failure, infection, wire breakage or disattachment, and reversion to a sinus rhythm with competition for ventricular activation between the heart's own pacemaker system and the electronic device.

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**Electrodyne Company, Norwood, Mass.

***Cordis Corporation, Miami.

Pulse Generator Failure

Fifteen of the 22 survivors still have the original pulse generator unit in place (table 2). There are seven survivors who were operated upon more than 24 months ago and three of these still have the original unit in place. Nine patients still living were operated upon more than 18 months ago. Four of these have the original pacemaker unit still in place. Of the five patients who have had to have the pulse generator package replaced, battery failure can be implicated in only three. One patient has gone 31 months with the original pulse generator system still working well.

Widening of the pacemaker impulse as measured by the electrocardiogram, change in the pacemaker rate, and roentgen changes in the mercury batteries themselves have been reported to herald failure in the pulse generator system.[7,8] We have not noted these changes. Reduction in size of the pacemaker complex on the electrocardiogram does seem to occur with time.[8]

It seems apparent that patients with implanted pacemakers should be followed closely following pacemaker insertion. This is particularly true after 18 months have passed because of the increasing risk of component failure. Also, patients should be instructed to take their own pulse, and to return at any time that it slows below the established rate.

We have had one case in which the pacemaker rate increased to 100 per minute on the ninth postoperative day. The patient was watched closely and a new pulse generator unit was obtained to replace the original. During the next week, however, the pacemaker rate gradually slowed to 84 per minute where it has remained during the nine months that the patient has been followed since.

Increase in pacemaker rate has been reported to occur as a result of use of intense heat during sterilization of the pacemaker unit.[6] Our units have always been sterilized in a gas autoclave at 110 F. for eight hours. Twenty-four hours is al-

PATIENT	age	ELECTROCARDIOGRAM Pre-op	Post-op	SUBSEQUENT OPERATIONS
BJH	27	3° Heart Block	3°Heart Block	28 mo. wire grounded; 30 mo. battery replaced
MB	69	CHB	OCB	31 mo. battery replaced
WPG	60	CHB	CHB	Expired 7 mo.- Stroke
MP	58	CHB	Nodal Rhythm	29 mo. battery replaced
FK	59	CHB		Expired- Cerebral Ischemia
GM	75	2° CHB	OCB	None
FHE	82	CHB	CHB	Expired- Infection
HP	68	1° Occ.CHB	CHB	None
CT	72	CHB	CHB	5 mo. wire grounded - Expired 22 mo.-CHB
MAB	76	CHB	NSR	None
AS	64	CHB	50% NSR	17 mo. battery replaced
JM	62	CHB		Expired- Infection
DDC	55	CHB&NSR	2° Heart Block	8 mo. liberation lingula; 16 mo. Atricor inserted
NWF	76	CHB	CHB	None
EW	75	CHB	CHB	None
JMG	50	Varying Block	NSR	None
EH	67	CHB	OCB	4 mo. new unit, broken wires-6 mo. wires broken, R.V.unit inserted
NR	74	CHB	ONB	7 mo. Pacemaker removed, wire failure & infection;8 mo. R.V.unit inserted
EOA	68	2° & CHB	NSR	None
PDM	63	CHB	CHB	None
CPL	71	CHB	CHB	12 hrs. wire failure, new unit inserted
AJA	68	CHB	CHB	None
MEB	74	CHB	CHB	Expired 2 mo.- Stroke
CPF	74	CHB	NSR & Occ.CHB	None
WWO	62	CHB	CHB	None
CLW	69	NSR &CHB	NSR	Expired 5 days, Ventricular Fibrillation
FS	76	CHB	OCB	None
AN	59	NSR & CHB	NSR	None
FEB	73	CHB	CHB	None

CHB - Complete Heart Block
NSR - Normal Sinus Rhythm
OCB - Occasional Conducted Beat
ONB - Occasional Nodal Beat
RV - Right Ventricle

Table 1

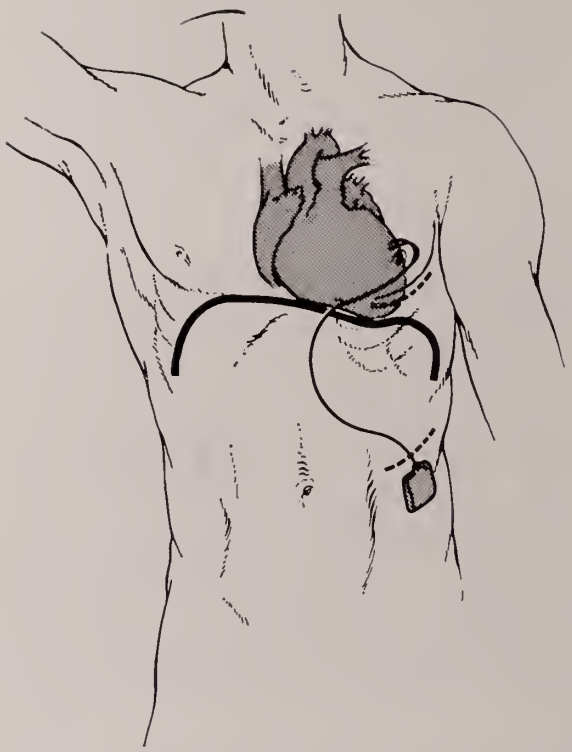


Fig. 1a.—Pulse generator package in abdominal wall beneath external oblique aponeurosis or rectus muscle with electrode wires passed through the central tendon of the diaphragm.

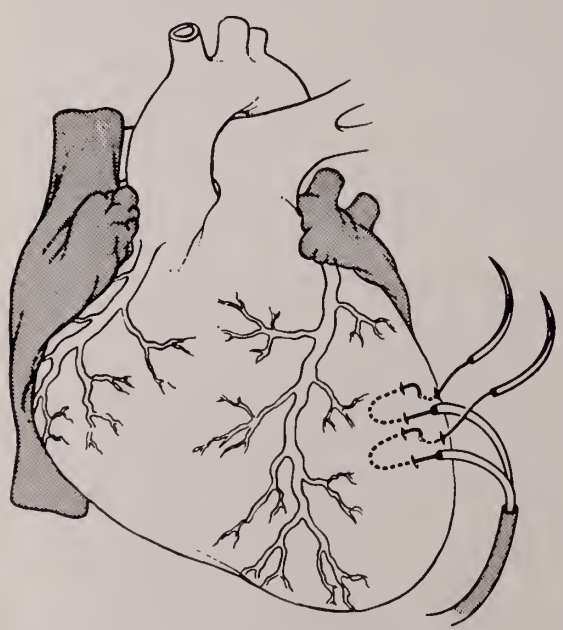


Fig. 1b.—Insertion of electrode wires into myocardium in two places. Sutures are placed at each entrance and exit point to help fix the wires in place.

Table 2.—Battery Failure

Survivors — 22
With original unit — 14

Survivors 18 months or more — 9
(One expiration at 22 months unrecognized wire failure)

Survivors 24 months or more — 7
With original unit — 3

lowed to elapse after sterilization prior to insertion to permit escape of the gas from inside the unit.[11]

Infection

Wound infection occurred in four of our patients resulting in two deaths (table 3). Both of the deaths occurred early in our experience in aged alcoholics with dirty skin, cirrhosis, incipient delirium tremens, and in one patient, severe chronic renal disease. Today, these two patients would be managed by inserting a right ventricular electrode attached to an external power source to provide ventricular stimulation long enough to bring them into optimum condition.[9] The new implantable pacemaker* with the electrodes impacted into the right ventricular endocardium may well be ideal for such patients.[3]

The last patient to have a wound infection around the original unit was successfully managed in this way. This patient was an elderly man who was operated upon recently and in whom a superficial wound infection developed that communicated with the electrode wires. Two months later the ventricle stopped responding to the electronic device. The entire unit was removed. Dense scarring was found around one of the myocardial electrodes and the other electrode had separated from the myocardium. A ventricular response was elicited by grounding the separated wire. A new right ventricular electrode was inserted via the external jugular vein and attached to a pulse generator which was implanted beneath the right pectoral muscle. The patient has been followed only two months since his second operation, but his wounds have healed and he has continued to follow the electronic pacemaker.

In one patient a superficial wound infection developed which healed secondarily without the need for removal of the pacemaker. This patient is still doing well and has had her original unit in place for over two years.

*Medtronic Incorporated, Minneapolis, Minn.

The fifth patient had an infection problem of a different type. The tip of the lingula became entrapped by the pacemaker wires in their intrapleural course. This patient had to be reoperated upon to disengage the lingula and stop the recurring atelectasis and pneumonitis. This problem could have been avoided by fixing the pacemaker wires to the parietal pleura or pericardium in several places along their course within the thorax.

Electrode Wire Breakage, Disattachment or Increase in Myocardial Threshold

Four patients have had wire problems that required reoperation (table 4). The first patient had a slow pulse after hysterectomy and salpingectomy were carried out 28 months after implantation of the pacemaker. One of the wires was grounded to the subcutaneous tissue and the pacemaker again elicited a ventricular response. A month later the pulse again slowed. At reoperation, one broken wire was found and the other wire had become dislocated from the myocardium. An entire new unit was inserted that was working well when the patient was last seen eight months afterwards.

Table 3.—Infections

Wound infections — 4 (2 deaths)
Recurrent atelectasis — 1

Table 4.—Wire Failures

Breakage — 4
Separation from myocardium — 3

In one other patient, simple grounding of a wire for failure of ventricular activation five months after the original insertion of the pacemaker resulted in satisfactory ventricular activation for 16 months. Then the patient was seen in the emergency room where an electrocardiogram showed dissociation of the pulse generator impulse and the ventricular complex. This was not recognized and she was sent home with an idioventricular rhythm at a rate of 60 per minute. Death occurred at home 20 hours later before the patient could be contacted and returned to the hospital.

Another patient was seen four months postoperatively with a slow pulse and electrocardiographic evidence of an idioventricular rhythm. Roentgenograms showed a broken wire in the substernal area. Operation was carried out under local anesthesia, and the wires exposed in their subcutaneous course in the abdomen. Grounding one wire did not result in pacemaker stimulation of ventricular contraction. Consequently, the other wire was bared of its insulation and cut. Both wires were then attached to an external pacemaker. There was still no ventricular response. The patient was then given a general anesthetic. At thoracotomy, one wire was found broken in the mediastinum and the other was dislocated from the myocardium. A complete new unit was inserted. This time the wires were attached to the lateral part of the left ventricle. They had previously been implanted in the right ventricular myocardium. Seven months after this operation, the patient was seen by her referring physician. At that time, she was asymptomatic. An electrocardiogram, however, again showed an idioventricular rhythm interspersed with a nodal rhythm so that the peripheral pulse rate was 72 to 74 per minute. Roentgen examination of the chest showed both wires broken in the substernal area (fig. 2). An excess loop of electrode wire was not left in the thorax at either the first or the second operation which probably explains the repeated wire breakage in this patient. An implantable pulse stimulator with right ventricular electrodes was inserted via the external jugular vein and has worked well during the two months since.

Reversion to Sinus Rhythm with Competition For Ventricular Activation

Eight of our patients with complete heart block have had sinus rhythm by electrocardiogram since the original operation to insert an implantable electronic pacemaker. In addition,



Fig. 2.—Posteroanterior view of chest showing fracture of both electrode wires.

another six patients were known to have intermittent heart block or episodes of asystole without complete heart block prior to operation (table 5).

Table 5.—Reversion to Sinus Rhythm
Prior to operation — 6
Subsequent to pacemaker insertion — 8

This finding means that in almost half of our patients (14 of 29) the possibility existed for competition between the heart's own pacemaker and the electronic device. Theoretically the electrical impulse could reach the heart during the vulnerable period of Wiggers[10] and cause ventricular fibrillation (fig. 3). Chardack[2] feels that the short duration of the pacemaker impulse makes this unlikely except in patients with unusual myocardial irritability due to coronary artery disease or other causes.

The catastrophe of ventricular fibrillation may have occurred in one of our patients. This patient had a sinus rhythm with episodes of complete heart block associated with syncope. A fixed rate electronic cardiac pacemaker was inserted. On the fifth postoperative day while shaving, the patient slumped to the floor. Resuscitative measures were carried out, and within a minute or two an electrocardiogram was made. This showed ventricular fibrillation. Further efforts with cardiac massage, positive pressure respiration and direct current external defibrillation failed.

Since this episode we have been using the atrially activated cardiac pacemaker in patients who do not have constant complete heart block. Previously, in an effort to increase atrioventricular block in patients whose heart had reverted to a sinus rhythm, we tried increasing their dosage of digoxin, quinidine, and potassium compounds. These medications failed to stop the competition for ventricular attention by the synthetic and natural pacemakers and increased the danger of arrhythmia due to the drugs themselves. We have not used procaine amide hydrochloride (Pronestyl) for this problem as suggested by Chardack.[2]

The atrially activated pacemaker[1] or a pacemaker that only goes into action when the ventricular rate is 50 or less may be as widely indicated as the fixed rate instruments for this type problem.[4]

Summary

Thirty-eight implantable pacemakers have been inserted in 29 patients at the University of Florida Hospital during the past three and one-half years. A total of 15 complications occurred. There are 22 survivors; three of the seven deaths were unrelated to the pacemaker. Two deaths were due to infection as a complication of the insertion of the pacemaker. One death occurred because of unrecognized electrode failure, and one death occurred on the fifth postoperative day, possibly as a result of ventricular fibrillation secondary to competition for ventricular stimulation by the myocardial versus the electronic pacemaker.

Of the 16 patients operated upon in the last 18 months only two have had to be reoperated upon, one because of electrode wire breakage and one because of infection.

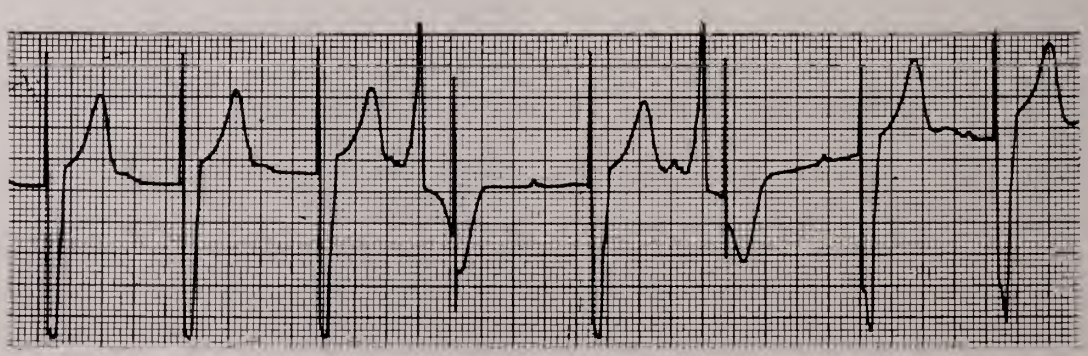


Fig. 3.—Electrocardiogram showing pacemaker impulse in the T-wave in a patient with complete heart block and a very occasional sinus-activated ventricular contraction with Wolff-Parkinson-White syndrome.

Of nine survivors living 18 months or more after the original pacemaker implantation, only four have not had to have operation for replacement of the pulse generator unit. Battery failure can be held accountable for the need for reoperation in three patients and wire problems in two.

On the basis of our experience, we believe that the intravenous right ventricular electrode with an external power source[9] should be used from the time of admission to the hospital until the patient is in optimum condition for operation. In very elderly, feeble or infected patients, the right ventricular electrode with an implanted pulse stimulator seems most desirable at present.[3] For complete heart block the fixed rate pacemaker has been reasonably satisfactory. The atrially activated pacemaker is used in patients with intermittent episodes of complete heart block associated with symptoms of cerebral ischemia.

Wire failure is handled by grounding first one wire and then the other in the subcutaneous tissue. If this fails to achieve a ventricular response, both wires are attached to an external power source. If this fails, a general anesthetic is given and a completely new unit implanted.

References are available from the authors upon request.

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Incarcerated and Strangulated Umbilical Hernia in Infants and Children

H. J. HURLBUT, M.D.* and THAD MOSELEY, M.D.**

The occurrence of incarceration or strangulation in umbilical hernia in infants and children is reported to be rare,[1-6] and as late as 1952 Brown[7] was able to find no report of strangulation in this type of hernia. The same is not true of umbilical hernia in adults, with one report stating that 17% of all adults hospitalized with umbilical hernia were admitted because of incarceration.[1]

Gravity of the erect position has been credited with playing an important role in this difference.[1] As the child usually does not walk until 12 to 15 months of age, by that time many of these hernias have closed,[8] a point well demonstrated in the study of 1,237 children reported by Crump[3] (fig. 1). Any cause of increased intra-abdominal pressure would seem to increase the incidence of incarceration.

Sibley, Lynn and Harris[2] reported only two cases of incarcerated umbilical hernia in infants at the Mayo Clinic and in both the patient had advanced nephrosis and ascites. They further stated that in three of the 16 cases reported in the literature, this same combination of disease was present. Severe coughing also has been implicated in the etiology of this condition.[9]

From the Department of Surgery, Duval Medical Center, Jacksonville, Fla.
*Assistant Resident Surgeon.
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Report of Cases

Twelve children with incarceration and one child with strangulation of umbilical hernia were admitted to Duval Medical Center between 1952 and 1965 (table 1).

Case 1.—A two year old Negro girl was well until 24 hours prior to admission when the umbilical hernia became incarcerated. The hernia was reduced during dissection of the sac. The child required four days' hospitalization.

Case 2.—A 17 month old Negro boy was well until eight hours prior to admission when the umbilical hernia became incarcerated. Nausea and vomiting followed. The hernia was reduced during the dissection of the sac. The child required five days' hospitalization.

Case 3.—A three year old Negro boy was well until 16 hours prior to admission when the umbilical hernia became incarcerated, and the child subsequently experienced nausea and vomiting. On admission the peripheral blood smear revealed 50% sickling. At operation the umbilical hernia contained small bowel with a bolus of Ascaris lumbricoides worms. The child required four days' hospitalization.

Case 4.—A 20 month old Negro boy was well except for a mild infection of the upper respiratory tract until incarceration of the umbilical hernia occurred 24 hours prior to admission. His temperature was 103 F. on admission and rales were present in the chest bilaterally. The umbilical hernia was reduced on dissection of the sac. The bowel was examined and found to have one area of gangrenous ileum 3 cm. from the ileocecal valve. The child died postoperatively. Postmortem examination revealed numerous ruptured alveoli in the lung.

Case 5.—A two year old Negro boy was well until six hours prior to admission when the umbilical hernia became incarcerated. The sac contained the terminal ileum and cecum, including the appendix. The child required four days' hospitalization.

Case 6.—A 13 month old Negro boy was well until incarceration of the umbilical hernia occurred on the morning of admission. The hernia contained small bowel with impacted feces. The child required three days' hospitalization.

Case 7.—A six year old Negro boy was well until incarceration of the umbilical hernia occurred 12 hours prior to admission. The hernia contained omentum. The patient required four days' hospitalization.

Case 8.—A 10 month old Negro boy had an infection of the upper respiratory tract with a cough, prior to incarceration of the umbilical hernia on the day of admission. The hernia contained omentum. The patient required four days' hospitalization.

Case 9.—A 13 month old Negro boy was well until incarceration of the umbilical hernia occurred 24 hours prior to admission. The hernia was reduced after the child was put to sleep. The child required five days' hospitalization.

Case 10.—A seven year old Negro girl was well until incarceration of the umbilical hernia occurred on the day of admission. The hernia contained the transverse colon, with feces and omentum. The child required four days' hospitalization.

Case 11.—A six month old Negro girl was well until 48 hours prior to admission when the umbilical hernia became incarcerated. The hernia contained small bowel. The child required three days' hospitalization.

Case 12.—A four year old Negro girl was well until six hours prior to admission when incarceration of the umbilical hernia occurred. The hernia contained small bowel. The patient required four days' hospitalization.

Case 13.—A one year old Negro boy was well until eight hours prior to admission when the umbilical hernia became incarcerated. The hernia contained cecum. The child was released after three days' hospitalization.

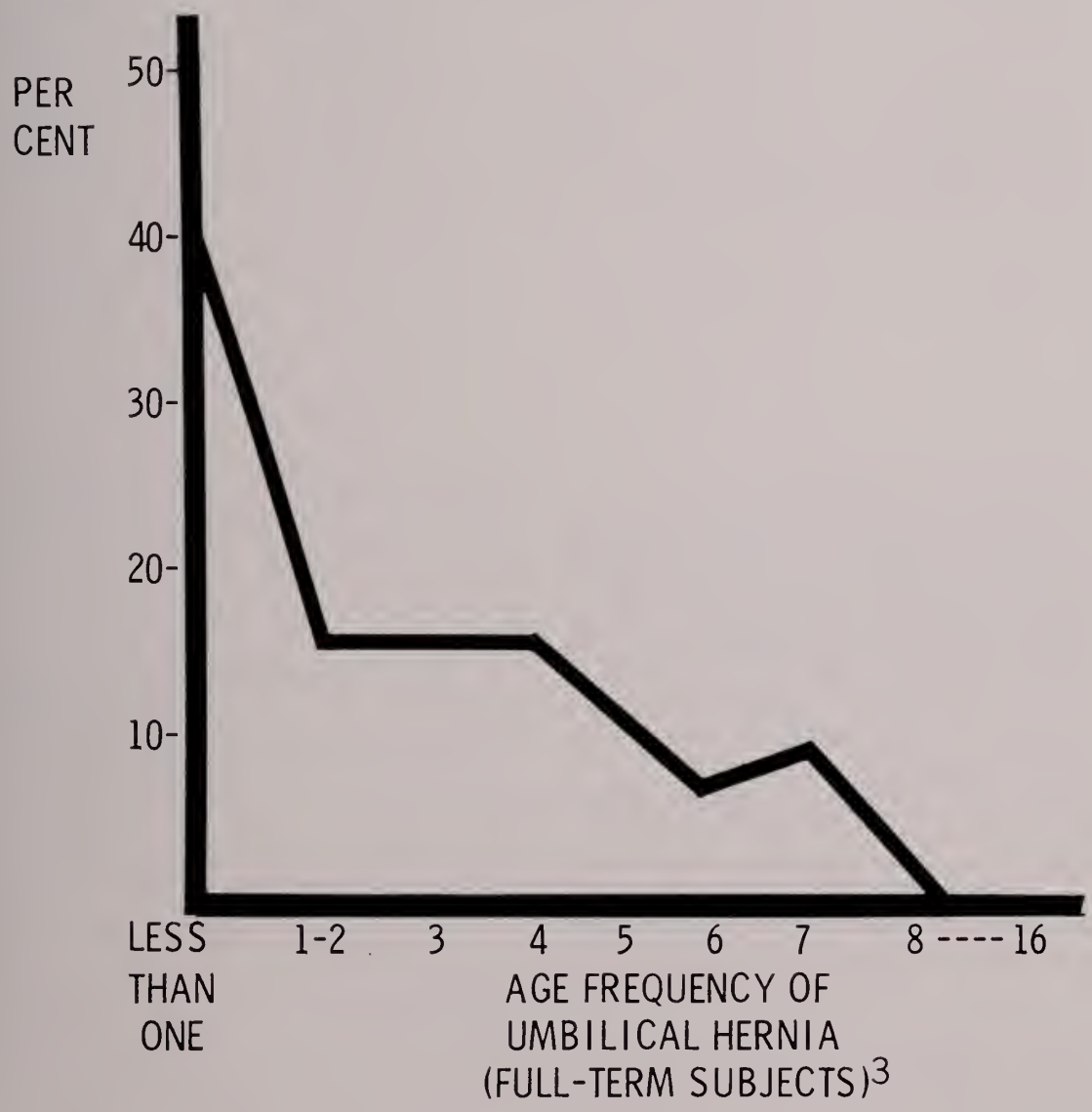


Figure 1

Table 1

Patients	Age	Race	Sex	Length of Incarceration (Hours)	Prior Health	Hernia Sac Contained	Length of Hospitalization (Days)	Results
1	2 yr.	N	F	24	Good	Reduced during dissection	4	Good
2	17 mo.	N	M	8	Good	Reduced during dissection	5	Good
3	3 yr.	N	M	16	50% Sickling	Small bowel with Ascaris bolus	4	Good
4	20 mo.	N	M	24	URI with cough	Gangrenous ileum	Died	Died
5	2 yr.	N	M	6	Good	Terminal ileum, cecum with appendix	4	Good
6	13 mo.	N	M	14	Good	Small bowel with impacted feces	3	Good
7	6 yr.	N	M	12	Good	Omentum	4	Good
8	10 mo.	N	M	Unknown	URI with cough	Omentum	4	Good
9	13 mo.	N	M	24	Good	Reduced during dissection	5	Good
10	7 yr.	N	F	Unknown	Good	Transverse colon containing feces, Omentum	4	Good
11	6 mo.	N	F	48	Good	Small bowel	3	Good
12	4 yr.	N	F	6	Good	Small bowel	4	Good
13	1 yr.	N	M	8	Good	Cecum	3	Good

Discussion

During the years 1952 to 1965, 12 patients with incarcerated and one patient with strangulated umbilical hernia were treated at Duval Medical Center. During this same period, 115 children were admitted for surgical repair of large persistent umbilical hernias. The incidence of 11.3% in this series would suggest that these complications occur more frequently than has previously been reported.

Except for mild upper respiratory infection associated with cough in two children and a 50% sickling on the peripheral smear with Ascaris lumbricoides infestation in one child, all of these patients were in good health until the time of incarceration. That all were Negro patients was not surprising for Crump[3] stated that umbilical hernia is eight times more frequent in Negro than in white children. The ratio of Negro to white pediatric admissions in this hospital is approximately 3.2 to 1. There was a marked preponderance of males in this series. The time from incarceration to admission varied from six hours to 48 hours, with an average of 17.2 hours. The average length of hospitalization was four days, and one death occurred.

Summary

Twelve cases of incarcerated and one case of strangulated umbilical hernia occurring in infants and children are reported. In this series all were Negro children with males predominating. It is suggested that these complications may occur more frequently than has previously been suspected. In these cases the children were in good health prior to incarceration, and no predisposing factors such as cough were noted. While it is true that most umbilical hernias close spontaneously, physicians should be alert to these possible complications needing surgical treatment.

References are available from the authors upon request.

Dr. Hurlbut, Duval Medical Center, Jacksonville 32206

Use of Paramethasone, Propoxyphene, and Aspirin In Musculoskeletal Problems

WILBUR J. BLECHMAN, M.D.

In private practice a considerable proportion of cases in general practice and internal medicine involve the musculoskeletal system but do not require definitive orthopedic care. The problems of therapy are evidenced by the remarkable numbers of medications available to the practitioner, none of which give consistently good, safe results. Adding further difficulty to the evaluation of these medicines is the known effectiveness of the placebo in many disorders of a rheumatologic nature.

A mixture of Aspirin, Darvon and Haldrone* was found to provide significant relief in a series of patients with varied musculoskeletal problems.

Materials and Methods

One hundred men and women over the age of 15 from an internal medicine and rheumatology private practice were included in this study. The mixture of Aspirin, 500 mg., Darvon, 32 mg., and Haldrone, 0.25 mg., was given to any patient who it was thought might benefit from the drug. No attempt was made to omit patients who might have responded to other medications with or without corticosteroids. In some it was the initial therapy. In others it was given a trial after failure of other medication. Still others had it added to previous therapy.

Only the first 100 patients in whom a probable or definite clinical diagnosis could be established were considered in this report. Therapy was completely individualized. The initial dose was instituted according to the type of illness, the weight of the patient and consideration of response to previous medications, if known. Dosages were raised or lowered according to the patient's response.

Included in the study group were 25 Caucasian men, 74 Caucasian women and one Negro woman.

Table 1 lists the different disease states and the number of cases of each:

*Stero-Darvon with A.S.A., paramethasone, propoxyphene, and aspirin, Eli Lilly and Company, Indianapolis, Indiana.

Table 1. — Disease States

Osteoarthritis	34
Musculotendinous sprains	23
Rheumatoid arthritis	18
Tenosynovitis	11
Periarthritis (capsulitis)	4
Fibrositis	5
Joint effusions, nontraumatic	1
Coccydynia	1
Systemic lupus erythematosus	1
Polymyalgia rheumatica	1
Multiple myeloma	1

Diagnosis

The diagnosis of osteoarthritis, musculotendinous sprains, tenosynovitis, joint effusions and coccydynia caused no problems. In all cases of rheumatoid arthritis, the ARA criteria for definite or classical rheumatoid arthritis were met. The one lupus patient had a positive L. E. preparation without renal involvement. Criteria for diagnosis of fibrositis were obtained from Hollander's Arthritis. For polymyalgia rheumatica, the differential diagnosis in Copeman's Textbook of the Rheumatic Diseases was utilized. Multiple myeloma was initially not correctly diagnosed. Indeed the absolute lack of response to the medication led to looking for other sources of back pain, following which the diagnosis was correctly established.

Results

Definition of successful and unsatisfactory related to the patient's own evaluation of how he felt plus the examiner's opinion (table 2).

Table 2. — Results of Therapy

	Satisfactory	Unsatisfactory
Osteoarthritis	28	6
Musculotendinous sprains	17	6
Rheumatoid arthritis	9	9
Tenosynovitis	10	1
Fibrositis	4	1
Periarthritis (capsulitis)	3	1
Systemic lupus erythematosus	1	0
Coccydynia	1	0
Polymyalgia rheumatica	1	0
Multiple myeloma	0	1
Idiopathic joint effusions	1	0

Results were very good in all groups except rheumatoid arthritis and the one case of multiple myeloma.

The large percentage of good responses in osteoarthritis is made more impressive by the inclusion in this group of six patients with severe hip involvement (table 3). Three of these patients had previously been considered to have intractable pain, in spite of numerous preceding medications. The remainder of the osteoarthritis group also responded well. It was interesting that the x-ray appearance of the affected joint would not allow an accurate prediction of the response. It was also impossible to predict the result of therapy in patients with musculotendinous sprains. Neither site involved nor severity of the symptom offered any clue.

Table 3. — Results in Osteoarthritis

Osteoarthritis	Number of Cases	Successful	Unsuccessful
Generalized	7	6	1
Knee	7	5	2
Hands	2	2	0
Hip	6	5	1
Neck	9	6	3
Spine	3	2	1

It was clear that results in rheumatoid arthritis were dependent on the activity of the disease (table 4). Rheumatoid arthritis in a burnt-out stage or a highly active stage was unlikely to respond, though good results were obtained in six of seven patients whose arthritis was only moderately active and not far advanced.

Table 4. — Results in Rheumatoid Activity

Rheumatoid Activity	Number of Cases	Successful	Unsuccessful
Active severe	6	2	4
Chronic severe	5	1	4
Active moderate	7	6	1

Most of the cases of tenosynovitis were subacute by the time Stero-Darvon with A.S.A was begun. Frequently the patient had received corticosteroids into the tendon sheath with partial relief.

None of the cases diagnosed as fibrositis had responded to other medicines, including moderate dosages of corticosteroids alone. The beneficial effect of Stero-Darvon with A.S.A, therefore, was a pleasantly surprising response.

All patients with periarthritis had received initial injections into the shoulder joint with partial benefit before receiving this compound.

The results in the remaining single cases were clearcut. Therapy in the successful cases has been maintained up to 28 months.

Side Effects

Side effects were moderately frequent but very mild and often dose-related or temporary. Only

two patients stopped the medication because of side effects. In one case, the patient took the first dose, became nauseated and refused to take any more. The second patient had previously claimed an "allergy" to Aspirin. When she took the Stero-Darvon with A.S.A she felt the same as when taking A.S.A; so she also stopped.

Gastrointestinal complaints were most common, being present in 26 patients. This effect was temporary and subsided without a change of dose in five and was obviously dose-related in an additional seven. Nausea, constipation and abdominal discomfort were the most common problems.

The next highest incidence of complaints was of fatigue, tiredness and weakness in 14 patients (many overlapping with those having intestinal symptoms). Here also symptoms were temporary in three and dose-related in two patients.

Six patients complained of diaphoresis (Aspirin effect) and three of tinnitus which responded in two to lowering the dose.

Four patients had symptoms considered to be related to the steroid. All four had ecchymoses and two of these had a moon-shaped face. These latter had been taking eight Stero-Darvon with A.S.A tablets daily for months. In each instance the patient had osteoarthritis of the hip. No other significant symptoms were present.

No attempt was made to obtain laboratory data routinely. On the few determinations made, no significant changes were apparent.

Since most patients were informed that they were being given an investigational compound, one must consider the possibility that this knowledge may have played a significant role in the production of side effects as well as beneficial effects through a placebo mechanism. No long term clinical complications of Haldrone therapy were observed.

Discussion

Stero-Darvon with A.S.A is a compound which gave good results in a majority of 100 patients with varied rheumatic complaints. These were patients in a private practice in which an adequate follow-up was maintained. All patients were seen on each visit by me. Because Stero-Darvon with A.S.A was used at times with other medications or after other drug trials, an added problem in evaluation was present.

A strong impression was obtained that good results after poor results with previous therapy were real in most cases, if not all. The remainder of the patients received Stero-Darvon with A.S.A as initial therapy. It was easier to determine responses in these patients.

Certain interesting clinical features were noted:

The ameliorating effect of the compound on the previously intractable pain of severe osteoarthritis of the hip has been mentioned. The largest doses (eight tablets daily) were generally given to this group, but the patients' happiness with therapy was quite vocal.

Patients were obviously pleased with the relatively small number of pills which they had to take in a day. This, in turn, definitely was a contributory factor in their continuing therapy.

Even in those patients who did not obtain "good" results, some lessening of symptoms was usually apparent. It was the absolute lack of response in the patient with multiple myeloma which led to further diagnostic studies.

Several of the rheumatoid and osteoarthritic patients were able to decrease significantly their steroid and/or narcotic dosages by using Stero-Darvon with A.S.A.

In a few cases this compound gave a good result, whereas prior therapy with steroids in moderate dosage had not been considered beneficial.

In osteoarthritis, periarthritis, tenosynovitis and some cases of rheumatoid arthritis, there seemed to be much less of a need to use local corticosteroid injections while the patient received Stero-Darvon with A.S.A.

Conclusion

A compound of Darvon, 32 mg., ASA, 500 mg., and Haldrone, 0.25 mg., was used with good results in a large percentage of patients with rheumatic complaints from several causes. Therapy has been maintained up to 28 months without appearance of significant side effects.

Stero-Darvon with A.S.A was well tolerated and well accepted by the patients.

This study was aided by a grant from Eli Lilly and Company.

Dr. Blechman, 995 North Miami Beach Boulevard, North Miami Beach 33162

George Saxon Palmer, M.D.
Eighty-Sixth President

George Saxon Palmer, M.D., was elevated to the presidency of the Florida Medical Association at the Ninety-Second Annual Meeting held May 12-15 at the Diplomat Hotel, Hollywood Beach.

Dr. Palmer represents the fifth generation of Palmers to practice medicine, and the third member of the Palmer medical lineage to have attained the FMA presidency. His father, Dr. Henry Edwards Palmer, was elected to the FMA presidency in 1909; and his great uncle, Dr. Thomas Martin Palmer, was the Association's second president in 1876. During the five generations the Palmers have been in medicine, 14 have been practicing physicians. Two of Dr. Palmer's brothers are presently practicing physicians — Dr. Thomas Myers Palmer, Jacksonville, and Dr. Martin Palmer, New Orleans.

Dr. Palmer is presently a practicing pediatrician in Tallahassee. Born Feb. 18, 1917 in Tallahassee, he attended local schools and was awarded a Bachelor of Science degree, with honors, by the University of Florida in 1937. He received his Doctor of Medicine degree from the Johns Hopkins University School of Medicine in 1941. After completing an internship at the Harriet Lane Home, Johns Hopkins Hospital, Dr. Palmer entered the Army Medical Corps.

During Dr. Palmer's four years in the Army Medical Corps, where he attained the rank of major, he served in the Third Army through General Patton's campaign in Europe and was awarded five battle stars for campaigns in France, Luxembourg and Germany.

In January 1946 Dr. Palmer returned to Johns Hopkins Hospital to become assistant resident in pediatrics, rising to resident on the private pediatric service of the Harriet Lane Home and resident physician at Sydenham Hospital for Contagious Diseases in Baltimore. He began the private practice of pediatrics in his home town of Tallahassee in February 1948.

In his years with the FMA since 1948, Dr. Palmer served first as a member of the Council



(1953-55) and since has been on the Board of Governors (1957-59), chairman of the Committee on State Legislation (1963-65), chairman of the Committee on Medicine and Hospitals (1964-65), a member of Reference Committee 3 (1963) and chairman of Reference Committee 3 in 1964.

A licentiate of the American Board of Pediatrics, Dr. Palmer also holds membership in the American Academy of Pediatrics, Florida Pediatric Society, Johns Hopkins Medical and Surgical Association and American Medical Association.

Offices held by Dr. Palmer in other medical organizations include chairman of the Committee on Board of Medical Examiners of the Florida Pediatric Society (1955-63); chairman of the Committee on Blue Shield of the Florida Pediatric Society (1952-64); vice president of the Blue Shield of Florida Board of Directors (1956-62) and president of the Florida Board of Medical Examiners (1958-59).

During his army service, Dr. Palmer was married to Marie Margaret O'Leary of Staten Island, New York, on Aug. 18, 1943. They have two sons and three daughters.

President's Page

FMA and the Future

We all agree that after July 1, 1966, when PL 89-97 becomes effective, things will not be the same again. This date will mark the beginning of many changes in the practice of medicine as we have known it. Every practicing physician, no matter what his specialty, will be affected.

How shall we react? What should be our attitude? These are questions which can be answered only by each individual physician according to his pre-existing attitudes, conscience, ethical and moral standards. I would like to offer some suggestions to our membership, fully realizing that no one of us has all of the answers or the solution to the changes which confront us.

PL 89-97 is the law of the land. We should recognize that fact and not consider ourselves above the law as so many in civil rights have done.

We should even more strongly follow our Code of Ethics and do what is best for the welfare of our patients. We represent a self-regulating profession of the highest standards. We are not a union. Let us act accordingly.

We must recognize changes, even though we do not approve of them in principle. The pressure producing these changes is steady, relentless and inexorable.

We should not be afraid to try the new. For example, we should support Dr. Hampton's program for funding indigent and needy medical care, which he has so carefully and painstakingly developed and proposed. This leads to the next statement.

We must keep the practice of medicine in the hands of the doctors and not allow it to be in the hands of hospital administration or any segment of government.

We must become more interested in, active in and participate in politics and in the socioeconomic facts of life. How can we know what is best if we do not know and understand what is going on?

We must act as physicians and honorable gentlemen and do what is best for our patients, our profession and our Association in the broadest sense and not present the impression that we are guarding selfish and narrow interests either personal or in our specialties. We are all doctors.

It is better to use terms such as "assignment" or "nonassignment" rather than "participate" or "nonparticipate" lest we be wrongly accused of striking or refusing to care for our patients.

Finally, each of us must be willing to serve our profession and our Association when called upon and devote time, energy and loss of income if necessary toward achieving our goals and purposes.

Your President and your chosen leaders and representatives are at your service. We do not know all and we cannot do all. We expect your help as well as your constructive criticism. We need your confidence and support. I will do all that I can to keep informed and to carry out the policies of our Association.

"Honor and shame from no condition rise;
Act well your part, there all the honor lies."

Essay on Man
Alexander Pope

George S. Palmer



Automotive Crash Injury Research Study

An intensive four year research study aimed at helping to make automobiles safer "packages" for drivers and passengers began its fifth six month phase on April 1, 1966, in Florida.

Members of the Florida Highway Patrol and staff physicians of participating hospitals are cooperating with the ACIR project of the Cornell Aeronautical Laboratory, Inc., in a special study of automobile accidents. Special forms are used to report the nature and extent of injuries and the precise causes of injuries sustained by occupants of passenger cars involved in accidents. The new study is limited to the injury-producing accidents of the four most recent year model cars.

The current ACIR study involves the cooperation of the Florida Highway Patrol, the Florida Medical Association, Inc., the Florida Hospital Association, and the Florida State Board of Health. The fifth six month phase of the program will take place in the Highway Patrol's Troop D, which includes the counties of Brevard, Flagler, Lake, Orange, Osceola, Seminole, and Volusia.

The primary objective of the ACIR program is to study the relationship between passenger car design and injuries sustained by occupants. It is estimated that thousands of American motorists may already have been saved from injury and death by the application of Cornell data to engineering safety designs aimed at increasing passenger protection.

Completed case histories of accidents, including Florida Highway Patrol-ACIR reports, photographs, and ACIR medical reports, are coodinated by Dr. George McCoy, Director, Accident Prevention Division, Florida State Board of Health. Completed case reports will be forwarded to Cornell in Buffalo, N. Y. for analysis and statistical interpretation.

As the Florida-Cornell ACIR study is at the halfway mark, preliminary tabulations have shown that in the 1,095 accident cases investigated, over 2,025 occupants sustained injuries ranking in severity from minor to fatal. The resulting pool of medical and accident data from the ACIR program has made it possible to produce statistical findings that serve as a basis for automotive design changes aimed specifically at reducing the frequency and severity of injury in accidents. Based on the ACIR studies, design modifications such as improved door holding mechanisms, recessed steering wheel hubs, padded instrument panels and sun visors, and seat belts have been effective in reducing injury.

Officials of the ACIR project are convinced that much can be done to mitigate future injury by means of vehicle design if only the mechanisms and type of injury are thoroughly understood. Solution to the problem is sought by statistical analysis of injury occurring in automobile accidents throughout the nation.

The basic functions of ACIR are accident data collection; analysis of injury causation; recommendation of corrective action and evaluation; general dissemination of information on the causes of injury, their types, frequency of occurrence; and relation to vehicle configuration.

Francis T. Holland, M.D., Chairman
Medical Advisory Committee to
Florida State Department of Public Safety
Tallahassee

The Problem of Illegitimacy

Legally, an illegitimate child is one born to a mother not married at the time of conception and who remains unmarried through the gestation period and the time of delivery. If the mother was married at the time of conception or delivery, the attending physician has no choice but to register the child as legitimate, listing the husband as father. This is necessary even if the mother or husband, or both, should insist that he is not the father, for the rights of the child must be protected. A child born to a married mother can be determined illegitimate only by the court.

During 1964 in the Bureau of Vital Statistics of the Florida State Board of Health, 12,514 babies were recorded as having been born to unmarried mothers, an increase of 628 over the previous year and a 74% rise within the decade. There is wide variation in the proportion of births which are illegitimate for the white and nonwhite races, the nonwhite being approximately seven times higher. During the past 10 years, the percentage of illegitimate births to white mothers increased from 2 to 4%, the nonwhite from 26 to 30%.

One of the distressing aspects is the high proportion of illegitimate births among teenagers. In 1964, of all births to white teenage mothers, 10.2% were illegitimate, accounting for 40.8% of the total white illegitimate births. For the nonwhite, 53.5% of births to teenage mothers were illegitimate and 43.8% of all illegitimate births were to mothers under 20 years of age.

There was some increase in illegitimacy during the war years 1941 through 1945, but the increase accelerated sharply in the succeeding five years. Since that time, the trend has been continuously upward. The proportion of white births that were illegitimate varied little until after the war had begun, then from 1943 to 1947 it increased from 1.0% to 1.6% and by 1950 rose to 1.8%. The largest increase came between 1954 and 1964 when the proportion doubled. Among nonwhite women, illegitimate births had the greatest increase in the period between 1940 and 1950, rising from 17.4% to 23.2% of all nonwhite births, mostly in the postwar years.

In Florida, the illegitimacy ratio per thousand live births has exceeded that for the United States each year during the past decade. In 1963, the latest year for which national figures are available, Florida's ratio was 63% above that for the nation; however, this is almost entirely the result of the higher proportion among the nonwhite race. The ratio for the white race as compared with that for the nation has shown little difference over the past decade.

At the present time in the United States, an estimated seven million persons are of illegitimate birth. They represent 4% of the total population and include 4% of the nation's children under 18 years of age. In a country where marriage and the family are the foundation of a way of life, this ratio becomes serious for illegitimacy is one symptom of a nation's illness, possibly cultural, social, economic, environmental, moral, emotional and psychological.

A few years ago concepts such as immorality, bad companions and mental deficiency were used in explaining illegitimacy; later the loss of parents, or a parent, in early childhood, poverty and the impermanence of homes were mentioned in reports on unwed mothers. The psychiatrists from their observations in outpatient clinics added emotional immaturity and character disorders. More recent factors have been enumerated as inadequate education and training for specific employment leading to limited opportunities and earning capacity, poor housing, instability of the family, insufficient health care and physical disability.

The attitude regarding sex and greater freedom in sexual behavior appear to be factors in the increasing illegitimacy rates. There is an inordinate preoccupation with sex in advertising, motion pictures, television programs, drama and other entertainment, as well as in certain types of books, magazine articles and illustrations. Inadequate sex education in the preteen and teen years of the present generation of young people may have resulted in the present, apparently successful, monetary exploitation of sex symbols.

The practice of "going steady" early in the teen years, greater freedom allowed by parents and general availability of automobiles could be contributing factors as well as liquor, pep pills and other barbiturates.

Parents who are emotionally unstable and the environment created by them may lower the child's sense of values and lessen his ability to cope with outside influences. Their attitudes, the extent of their love for each other and the understanding, warmth, affection and acceptance of their children have a great deal to do with the capability of the adolescent to withstand the pressures to which all young people are exposed in the process of growing up. Spiritual and emotional deprivation creates special problems, adding to those which will exist even in the most normal of American homes.

There is no formula which can be easily applied to prevent illegitimacy. Many solutions have been tried over the years. The situation appears to be a portion of a larger cultural problem related to the responsibilities of parents, schools and churches.

Many physicians are being helpful; more could be influential. The family doctor usually is among the first to learn of the pregnancy of the unmarried girl because of the need for his advice. He may have been closely associated with the members of the family for many years yet failed to emphasize the problems of adolescence which lead to most serious family and individual crises. He may have excused his reticence by accepting the easy explanation that his responsibilities were for specific illnesses. But his training equipped him to detect individual and family disorders through observation, and experience provided the wisdom to offer wise preventive counsel. If all of us, both public health and private practitioners, would observe more closely the problems of those around us; become more involved in these matters, possibly outside our primary interests, and offer sound advice, the combined effect would be heartening. We might be misunderstood or accused of meddling, and we would not completely solve the problem of illegitimacy. We should, however, slow the accelerating trend and in time, hopefully, bring the problem of illegitimate births under control.

Wilson T. Sowder, M.D.
State Health Officer
Jacksonville

Camp for Diabetic Children

The Florida Diabetes Association Camp for boys and girls 10 to 14 years of age was initiated in August 1962. The facilities of the Y.M.C.A. Camp, located in Keystone Heights, and 285 acres of camp lands were made available to the Florida Diabetes Association for its camp project. The camp, under the direction of Mr. Vernon Harper, Camp Director for the Y.M.C.A., is one of the best run camps in the Florida area.

Dr. Joseph E. Shipp, of the University of Florida College of Medicine, has headed the professional staff of the camp for the Florida Diabetes Association since its inception. Dr. Shipp was able to obtain the aid of five or six physicians from the College of Medicine in Gainesville, all of whom gave their time for the entire two weeks of the camp, each year. Two graduate nurses and five undergraduates assisted the medical staff. A large infirmary located on the grounds is available for any child in whom a trace of sugar in the urine, acetonuria, infections, or other disease develops. The children are taken to the infirmary and given proper medical care and treatment.

During the camp season, the children are taught to check their urine, to boil and sterilize needles and syringes in the proper way, and to give their own insulin injections. This training is given under the careful supervision of physicians and nurses.

Three meals and three snacks are served

daily. The food is weighed the first week, and during the second week is given under the direction of the dietitians. Clinic is held daily and lectures are given by physicians, nurses and dietitians on proper control of diabetes.

Camp this year will be held from August 7 to August 20. Mrs. Jack Van Der Beek is the secretary of the Florida Diabetes Association and coordinator of the camp. Her office, which is located at 1910 Riverside Drive East, Bradenton, will answer any questions regarding the camp, send brochures and application forms, and accept any donations which could be laid aside by Florida physicians or their patients for the running of the camp.

Mrs. Van Der Beek has worked for many years to organize the camp and in 1963 was honored by the American Diabetes Association as the Outstanding Layman in the United States. She herself had had diabetes for 38 years.

Neither words nor dollars can express the rewards gained by the Florida Diabetes Association's Camp for Diabetic Children. The officers and directors of the Florida Diabetes Association will be happy to answer any questions regarding the camp.

Seymour L. Alterman, M.D., President
Florida Diabetes Association
Miami Beach

Blue Shield Progress

In the mid-1950s there was a growing misunderstanding between many of the physicians of Florida and Florida Blue Shield. Physicians felt that Blue Shield was not responsive to their needs while Blue Shield was feeling the pinch of more and more competition in the health insurance field and had an urgent need for updating its contracts.

Acting on the resolutions from the Florida Blue Shield Board of Directors, in 1956 the House of Delegates of the Florida Medical Association agreed to appoint a committee of 17 doctors to act as an advisory to Blue Shield from the FMA and as a reference committee in problems of fee schedules, patient claims, new contracts and contract modification. The President of the FMA appointed four doctors from each medical district and a chairman at large. A successful attempt was made to appoint representatives from each major specialty. None of the physicians had any official connection with the Blue Shield Board of Directors or the FMA Board of Governors.

For the first two years of its existence this was a very hard-working Committee with four to six full committee meetings a year and monthly visits of members by a representative of Blue Shield. As the Committee became educated, it became a two way communication between the FMA and the Blue Shield Board of Directors; between Blue Shield and the practicing physicians, they educated the physicians of Florida about the services that Blue Shield was performing for them and their patients and also made them aware of the problems that Blue Shield had in marketing and servicing its contracts.

Realizing the need for a new service contract with broader coverage and with a more equitable fee schedule, the Committee conducted a fee survey of the entire membership of the FMA in 1957. This was the first such survey conducted on a statewide basis in Florida. As a result of the survey and the work of the Committee of Seventeen and the Blue Shield Board of Directors, the 1958 FMA House of Delegates approved a recommendation that Blue Shield present a new service benefit contract with a $5,000 family service benefit level and a single person level of $3,600 to be known as the Type A contract. The Committee studied and recommended a Major Medical Extended Benefits program. It worked with the New Contracts Committee of the Blue Shield Board of Directors, in developing these programs, which were first offered to the public in 1959.

When the Federal Employees Insurance Act was passed in 1959, the Committee of Seventeen, with the Blue Shield Board and the FMA Board of Governors, worked out a service benefit plan

to offer two levels of service benefits on this contract: a high option $6,000 annual family income and a low option $4,000 family income. Using the 1962 relative value as the base, the House of Delegates, in 1964, approved a change to $7,500 family income for the high option. This contract is now being offered as well to non-governmental groups. The Type 'K' contract was modeled after the low option and offering it to the public met with wide acceptance, particularly in replacing the Type 'J' contract.

The Committee of Seventeen is now working with the FMA Board of Governors and the Blue Shield Board of Directors in trying to develop a new concept in the prepayment field, the "Prevailing Fee Contract."

Your Blue Shield Plan is one of the most progressive plans in the country. It deserves your understanding support. This progress is due to good communications between Blue Shield and the practicing physicians of Florida. Your Committee of Seventeen is available to answer your questions, to hear your complaints and suggestions, and to help formulate a prepaid plan that will be of more service to you and your patient. The present members of the FMA Advisory Committee on Blue Shield (Committee of Seventeen) are:

L. Myrl Spivey, West Palm Beach
James L. Anderson, Coral Gables
Edson J. Andrews, Tallahassee
Ralph C. Aye, Tampa
Jack T. Bechtel, Indialantic
James D. Beeson, Jacksonville
Irving M. Essrig, Tampa
Raymond J. Fitzpatrick, Gainesville
H. Hoffman Groskloss, Miami
Jack A. MaCris, St. Petersburg
John R. Mahoney, Ft. Lauderdale
Henry G. Morton, Sarasota
Louis C. Murray, Orlando
Wiley M. Sams, Miami
Roger D. Scott, Fort Myers
C. Merrill Whorton, Jacksonville

L. Myrl Spivey, M.D., Chairman
Advisory Committee to Blue Shield
West Palm Beach

Are You Careless with Narcotics?

The most frequent charge made against doctors to the Florida State Board of Medical Examiners has to do with the misuse of narcotics.

In a few cases this is due to ignorance of the law. In most cases claiming ignorance of the law is an untrue excuse. Most doctors know right from wrong and can avoid all these pitfalls by merely using good judgment and common sense.

Did you know that it is unlawful to prescribe narcotics for a known addict to satisfy addiction alone?

Did you know that a physician must keep a record of all narcotics dispensed?

Did you know that it is unlawful to obtain narcotics by writing a prescription for a patient and using the drug to treat other patients?

Did you know that it is very unwise to write a prescription for a patient and to get the prescription filled yourself and to deliver it to the patient?

These are only a few of the pitfalls which can easily be avoided. It is easy to detect an addict if you are observant. Don't let this "low life" make a "sucker" out of you.

If a person unknown to you, as a patient, should request narcotic drugs, and you are in doubt as to the ailment complained of and the authenticity of such ailment, proceed with caution. Note the description of the person, and if possible, the means of travel, make and description of his car, tag number, and other details.

The Bureau of Narcotics knows most addicts. So, if you need more information and assistance, call your local narcotic office: Miami 379-0553 or 379-0227; Tampa 223-4697 or 223-4698; Tallahassee 222-5839; Orlando 423-6309; Jacksonville 354-3961.

Be alert!

Homer L. Pearson, M.D., Director
State Board of Medical Examiners
Miami

Do's For The Health Director

The article by Dr. John D. Milton, "The Public Health Physician and the Private Practitioner," appearing in this issue of The Journal, covers a subject long neglected. Doctor Milton's more than 40 years spent in successful private practice, his work with and in the leadership of the FMA and his long time active participation with the State Board of Health, uniquely qualify him to discuss this subject.

See article page 491

Preventive medicine and curative medicine can stay in step and shoulder to shoulder. We all see this demonstrated daily. The two disciplines, however, need a two way channel of communication with rarely a break in the continuity.

Continuity of service is necessary if the Health Director is to succeed in any community. He, like the private physician, needs time to become established. I accepted the directorship of a county health department as the ELEVENTH physician to do so during the previous NINE years. Needless to say, I inherited many unresolved problems —problems caused primarily by the lack of a continuing or permanently assigned health officer and partially by a breakdown in communication with the resultant unnecessary and mostly minor misunderstandings.

These misunderstandings and problems can be avoided if temporary appointments are held to a bare minimum. Be the appointee on his way up or on his way down, such an individual never really becomes a part of his community. I believe strongly that financial investment in a home (at one time every member of my staff either owned or was purchasing his home) and active participation in civic affairs are a convincing indication of permanency. Everyone, including your fellow physicians, will think that you plan to stay. This is as it should be for few patients would choose a personal physician temporarily residing in the area.

What appears to be a significant difference between the two disciplines was brought into being by a Florida law enacted by the 1931 legislature which reads in part: ". . . . for the control and eradication of preventable diseases and to inoculate modern scientific methods of hygiene, sanitation and the prevention of communicable diseases." In reality, the legal obligation of the public health position is a distinction without a difference, for all private physicians have the selfsame moral responsibility and are dedicated to the same goal.

The health officer must be cognizant of the fact that the difference is only in degree—percentage if you will. The private physician is dealing with and spending 95 per cent of his time with DISEASE (not because he prefers it that way, but of necessity) while we spend 95 per cent of our time with WELLNESS and in attempting to keep the people well.

"Doctor, you are not in private practice; I can say this to you," is a remark too often faced by the health officer. It impiles that in the opinion of some people they are free to make critical and unjustified comments about their medical treatment. The answer given to this remark and similar queries will determine the success and acceptance of the county health department and will give understanding to its operating philosophy.

The Health Director should conduct himself and his office at all times in such a manner that no one would expect him to be a willing listener to such remarks. His image should be the same as that of any other member of the medical fraternity. I have always attempted to establish a "gentleman's agreement" that if the doctors will believe only one half of the things they overhear about me, I will believe absolutely nothing derogatory about them.

Many health officers and several private physicians have been contacted in the preparation of this editorial. Everyone emphasized the importance of the health officer being active in LOCAL, state and national medical associations.

Big problems often begin as little ones at the monthly medical meeting. To recall one incident: a physician thought that the health department was treating his patients and so stated at the meeting. I apologized and asked for their names. When he gave them, a fellow physician came to my rescue.

He said, "Doctor, they are not your patients. They are mine now, and I asked the health department to treat them. Incidently, Doctor, you can have them back."

I have always published a weekly letter which is sent to each of the practicing physicians. They report the communicable diseases and the weekly tabulation is mailed to them. It carries announcements of forthcoming meetings and references to medical articles that some might have missed.

I encourage the private physician to call me immediately (collect, if he likes) when he thinks a problem of public health significance exists. Initiation of new programs and the changing or discontinuance of old ones are always discussed with him. Emphasis is placed on what we can do for him.

Since "half of knowledge is knowing where to find it," I believe that I am half as smart as any one of the private practitioners and have attempted to establish the reputation that we can get almost any information they need. I never underestimate their knowledge, however, on any and all matters related to public health (selfishly perhaps, hoping to receive modest amounts of reciprocity). They are a major part of every public health program. A strong health department always implies the support of the medical society.

No health department can work effectively in isolation. The private physician and the public health officer must continue to work hand in hand to meet the needs of the people in this rapidly changing and fast-whirling missilistic world.

James Basil Hall, M.D.
Tavares

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Others Are Saying



PMA Report On Investigational New Drugs

Editor's Note: In the spring of 1965, Austin Smith, M.D., president of the Pharmaceutical Manufacturers Association at the time, sent a carefully prepared questionnaire to the nearly 5,000 United States members of the American Federation for Clinical Research to obtain their opinions about the Food and Drug Administration regulations, "New Drugs for Investigational Use," which then had been in force slightly more than two years. Because of the wide attention given these regulations in the medical press and their broad effect on clinical investigation of new drugs, The Journal publishes the following summary of Dr. Smith's report.

T.M.

Survey Design and Purpose

In the spring of 1965, the PMA prepared and mailed a questionnaire designed to obtain the opinions of clinical investigators concerning the FDA regulations on New Drugs for Investigational Use (IND) promulgated in 1963.

The final survey form, accompanied by a letter signed by Dr. Smith and a pocket-sized edition of the IND regulations, was sent to the 4,600 United States members of the American Federation for Clinical Research. Useable responses were received from 27 per cent (1250) of the recipients.

History

An earlier survey was conducted on behalf of the Association of American Medical Colleges by Dr. William Kirby of the University of Washington in 1963. Dr. Kirby acted by distributing questionnaires through the deans of medical schools. The current study was intended as a follow-up of the Kirby survey.

Summary of Findings

The majority (70 per cent) of respondents indicated five or more years of experience in conducting clinical investigations of new drugs or biologicals. Forty-six per cent of the respondents indicated that 10 per cent or more of their time is devoted to IND work, the median being 17.5 per cent of the investigators' time.

Various specialties active in clinical investigation, with internists predominating, appeared to be reasonably well represented by the survey response. Board certification was held by at least three fourths of all respondents.

Many respondents have worked on more than one IND since the 1963 regulations. Three fifths of all activity in clinical investigation of drugs was pharmaceutical company-sponsored; the remainder were sponsored by a government agency, the investigator himself or other types of sponsors.

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Intragastric photography has provided a new and precise method of measuring the effectiveness of anticholinergic drugs. The transition from gastric motor activity to relaxation seen with effective doses of such drugs takes only a few seconds and is easily demonstrated.

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See for

Indications: Peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

Oral Dosage: Adequate dosage should be given for optimal results. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

Side Effects and Contraindications: Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. Pro-Banthine is contraindicated in patients with glaucoma, severe cardiac disease and prostatic hypertrophy.

1. Barowsky, H.; Greene, L., and Paulo, D.: Cinegastroscopic Observations on the Effect of Anticholinergic and Related Drugs on Gastric and Pyloric Motor Activity, Amer. J. Dig. Dis. *10*:506-513 (June) 1965.

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Complete gastric relaxation with Pro-Banthine. As this intragastric photograph demonstrates, gastric relaxation is attained with 6 mg. of Pro-Banthine intravenously; the antrum is relaxed and the pyloric orifice remains open. Full intravenous doses of atropine (4 mg.) produce no measurable effect.

SEARLE

Research in the Service of Medicine

Effect on IND Activities

Slightly more than half (55.7 per cent) of those responding to the question concerning the effect of the regulations on their investigation of new drugs stated that the IND regulations have either had no effect or have even resulted in increasing their investigative activities. No clear cut negative or positive opinion regarding the IND regulations was indicated.

Specific Requirements or Provisions

The three subjects on which opinions were most often expressed concerning provisions or requirements of the regulations were: (1) submission of credentials, (2) patient consent, and (3) reports.

Of the 84 per cent expressing a view on submission of credentials, only 2.6 per cent felt the requirements unsatisfactory. With respect to patient consent, 29.6 per cent indicated unsatisfactory while 36 per cent felt either that they were very good or excellent. Write-in comments to questions 7 and 8 amplified this finding in that of all changes or modifications recommended, change consent procedure ranked third. Regarding reports, 14 per cent registered unsatisfactory while 45 per cent regarded them very good or excellent.

Relative Success of the Regulations

Only 12 per cent of the investigators replying felt the regulations were fully successful in accomplishing the FDA stated purpose of eliminating all unnecessary risks to the public attending new drug development. Fourteen per cent asserted results unsatisfactory, 59 per cent indicated moderately successful and 15 per cent indicated no opinion.

Recommended Changes or Modifications

Most noted was the need for changes which would decrease the amount of paper work required. The next two most common recommendations for change were: (1) once approved, investigators should have more freedom, and (2) change consent procedure.

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Government News

Armed Forces Referral Program

Editor's Note: The preceding article was reviewed and approved for publication by George H. McSwain, M.D., of Daytona Beach, who is the member of the Association's Subcommittee on Liaison with State Agencies responsible for relationships with the Division of Vocational Rehabilitation, State Department of Education.

T.M.

The Division of Community Health Services, United States Public Health Service, Department of Health, Education, and Welfare, at the direction of the President, has established a nationwide referral, counseling, and follow-up program for Armed Forces medical rejectees, the Congress having authorized the United States Public Health Service to do so. This program is administered through contractual agreement between the Division of Community Health Services and a single State Agency designated by the State Governor. The Governor of Florida designated the Division of Vocational Rehabilitation, State Department of Education, to administer this program in Florida.

Operations began June 1, 1965. The contract is on a one year basis and subject to renegotiation at the end of the contract year. The Division of Vocational Rehabilitation has two counselor interviewers, located at the Jacksonville and Miami Armed Forces Examining and Entrance Stations, and five area counselors, located at Jacksonville, Miami, Orlando, Pensacola, and Tampa.

The purpose of the contract is to "Develop and Operate a Counseling, Referral, and Follow-up Program for Armed Forces Medical Rejectees including a Study Measuring the Value of Providing Medical Diagnostic and Evaluative Services."

How much? and Who pays? are always good questions. The program is funded 100% from Federal funds. Total funds allocated for the year in Florida are $134,838. Program funds cannot be used to pay for the cost of treatment. Funds may in some cases be used to provide medical examination and evaluation. If treatment is recommended and if the rejectee is able to pay for it, he will be counseled to get the treatment as a private patient. In the event of the rejectee's inability to pay for treatment he would be referred to a state or local community resource. Counseling is for the purpose of helping the rejectee to gain adequate understanding of the health problem or defect for which he was rejected and to seek treatment and rehabilitation. After counseling, diagnosis, and referral the full program for the individual involves follow-up study for as long as a maximum of six months to evaluate the results of his medical care.

Other than referral to physicians, rejectees will be referred to health departments, county clinics, vocational rehabilitation, or voluntary agencies with interests in the program. The rejectees included in this program are those that are rejected for medical reasons by examination at Armed Forces Examining Stations. Program funds are limited and not sufficient to permit counseling and referral for those young men disqualified at draft boards.

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Indications: Indicated in the therapy of acute severe infections caused by susceptible organisms and primarily by bacteria more sensitive to the combination than to either component alone. In any infection in which the patient can be expected to respond to a single antibiotic, the combination is not recommended. Signemycin should not be used where a bacteriologically more effective or less toxic agent is available. *Triacetyloleandomycin, a constituent of Signemycin, has been associated with deleterious changes in liver function.* See precautions and adverse reactions.

Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

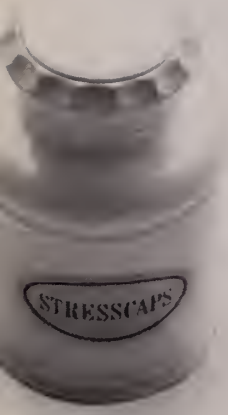
Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug. Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

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The human spine is not engineered
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set up by the heavy, forward-tilted h
and trunk, balanced precariously on
insufficient base, result in strain of
dorsal musculature, particularly at
low lumbar level.

The unusual muscle-relaxant and a
gesic properties of 'Soma' make it es
cially useful in the treatment of low b
sprains and strains. 'Soma' is wid
prescribed ☐ **to relieve pain** ☐ **to re**
muscles ☐ **to restore mobility.**

Indications: 'Soma' is useful for managemen
muscle spasm, pain, and stiffness in a variet
inflammatory, traumatic, and degenerative mu
loskeletal conditions. It also may act to norma
motor activity in certain neurologic disturban

Contraindications: Allergic or idiosyncratic r
tions to carisoprodol.

Precautions: 'Soma', like other central ner
system depressants, should be used with cau
in patients with known propensity for taking
cessive quantities of drugs and in patients
known sensitivity to compounds of similar che
cal structure, e.g., meprobamate.

Side Effects: The only side effect reported with
frequency is sleepiness, usually on higher t
recommended doses. An occasional patient
not tolerate carisoprodol because of an indivi
reaction, such as a sensation of weakness. O
rarely observed reactions have included dizzin
ataxia, tremor, agitation, irritability, headache,
crease in eosinophil count, flushing of face,
gastrointestinal symptoms.

One instance each of pancytopenia and le
penia, occurring when carisoprodol was adr
istered with other drugs, has been reported, as
an instance of fixed drug eruption with carisopr
and subsequent cross reaction to meprobam
Rare allergic reactions, usually mild, have inclu
one case each of anaphylactoid reaction with r
shock and angioneurotic edema with respira
difficulty, both reversed with appropriate thera
In cases of allergic or hypersensitivity reactic
carisoprodol should be discontinued and appro
ate therapy initiated. Suicidal attempts may
duce coma and/or mild shock and respira
depression.

Dosage: Usual adult dose is one 350 mg. tal
three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tab
and 250 mg. orange, two-piece capsules.

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EACH TABLET CONTAINS:

Pentobarbital Sodium	25 mg.
Secobarbital Sodium	25 mg.
Butabarbital Sodium	7.5 mg.
Phenobarbital	7.5 mg.

(WARNING: MAY BE HABIT FORMING)

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Chicago, Illinois, U.S.A.

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makes sleep irresistible



IN BRIEF:

EACH TABLET CONTAINS:

Pentobarbital Sodium	25 mg.
Secobarbital Sodium	25 mg.
Butabarbital Sodium	7.5 mg.
Phenobarbital	7.5 mg.

(WARNING: MAY BE HABIT FORMING)

Dosage: One or two tablets, one-half hour before bedtime.

Indications: For night-time sedation and refreshing sleep up to eight hours.

Contraindications: Patients sensitive to barbiturates. Use with caution in the presence of moderate to severe hepatic disease.

Supplied: Bottles of 100 tablets.

CAUTION: Federal law prohibits dispensing without a prescription.

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Association News

Committee Meetings

Editor's Note: The following are summaries of recent council and committee meetings. Final determinations on all actions or recommendations are made by the Association's House of Delegates at the Annual Meeting.

T.M.

Committee on Archives

The Committee on Archives met March 12 by telephone conference. A report was given on results obtained from listings sent to 33 county medical societies in November 1965 together with covering letters asking for completed data for archives forms. It was decided that the next effort would be a general mailing of another data for archives form to each of the 2,785 members who have not yet completed the form.

Plans for appropriate memorial services for deceased members at the FMA annual meeting were discussed. It was decided to honor FMA members who joined during the period of 1927-30 or 31 during the first meeting of the House of Delegates following the memorial service.

A project to compile a history of medicine in Florida was discussed and the chairman reported that no definite word has been received on his request for a grant which would permit study of uncatalogued Spanish documents. He advised that again in the summer of 1966 The Journal plans to publish a medical historical issue and urged all members to advise him of possible sources for articles for this issue.

It was suggested that FMA Associate Dues-Exempt members be suitably honored—either by presentation of a memorial or by having their names published in The Journal.

Committee on Nursing

The Committee on Nursing met jointly with representatives of the Florida Nurses Association February 12 in Orlando. The Vocational Rehabilitation program for training nurses' aides in Panama City was discussed. As it was heard that candidates for this program were handicapped either emotionally, intellectually or physically, the joint group decided that the FNA and the FMA should separately investigate this operation and, if conditions described proved to be true, lodge a protest to the State Department of Education from both organizations.

A motion carried that the FMA should support the FNA in its attempt to obtain realistic salaries for nursing personnel and it was further suggested that a statewide meeting of representatives from the FMA, FNA and Florida Hospital Association be held to attempt to solve this problem.

Science Fair Awards

"Some ideas being expressed by these young people have already gone beyond what science has accomplished in their fields of interest!"

This statement was made by one of the members of the judging committee for the Association's tenth annual awards in the 1966 Florida State Science Fair held April 14-16 in Bradenton. It typifies the reaction of the physicians who spent more than four hours selecting the winning exhibits from some 50 entered in the Science Fair's health and medicine category.

Donald N. Kapsch, an eleventh grader at Boca Raton High School, was picked as winner of the FMA first place senior award—a $1,000 medical school scholarship provided by the Florida Medical Foundation and a $100 savings bond. His outstanding exhibit was entitled "Is a Change in Gene Function the Key to Understanding Cancer?"

The first place junior award, a $50 savings bond, was won by Edward H. Arnold, a ninth grade student at Miami Edison Junior High School, for his exhibit "Fluoridation and Diet Control Caries and Health."

Winners of $25 savings bond honorable mention prizes furnished by the Association's Woman's Auxiliary were Robert C. Dillingham, Leon High School, Tallahassee; Richard B. Rosen and Agnes Tibor, both of Coral Gables Senior High School, and Michael R. Smith, Arlington Junior High School, Jacksonville.

The first place awards were presented by President Dr. H. Phillip Hampton of Tampa. Mrs. Frederick L. Patry of Bradenton, vice president of the FMA Woman's Auxiliary, presented the honorable mention prizes.

Members of the judging team were Drs. William D. Sugg (chairman), Irving E. Hall, John D. Lehman, Richard V. Meaney and Millard P. Quillian, all of Bradenton.

AMA Dues Increase

The AMA House of Delegates when it meets in Chicago this month will take final action on a recommendation of the Board of Trustees to increase annual AMA membership dues by $25—from $45 to $70—effective January 1, 1967. A number of physicians have requested facts on which the Board's recommendation was made. The following is an abstract of a paper prepared by the AMA to explain the basis of the proposed dues increase:

Cost of Doing Business

A major activity of the AMA is communications. In 1960, production of a typical page in its publications cost the AMA 11 cents, this year the AMA will spend 31 cents to produce the same page—an increase of more than 181 per cent.

Between 1959 and 1964, AMA real estate taxes almost doubled, from $66,000 to $112,000. The estimated tax bill for 1965 will be $200,000, an increase of more than 200 per cent over 1959.

The AMA must compete with private businesses in the market for personnel. In the last five years, AMA contribution to employee benefits has more than doubled and starting salaries for office employees in the Chicago area have increased by 25 per cent.

Due to Medicare, with added social security benefits, the social security taxes paid by the AMA will increase more than 72 per cent.

AMA Membership

The present membership of the AMA is 210,-938. Of this total, only 165,172 are dues-paying members. Those who do not pay dues include interns and residents, retired physicians, those in military service, others who serve full time in the military service or other government agencies and

some physicians who, because of accident or illness, have had their income partially or totally cut off.

Income and Expenditures

Membership dues, now $45 a year, will produce less than 28 per cent of AMA income in 1966. If the AMA did not have other sources of income, the current level of programs for the profession and the public would require annual dues of $165 per member.

The AMA budget for 1966 is narrowly in balance, after operating deficits of more than $1,000,000 were incurred in 1964 and 1965. Reserves were depleted by the amount of the deficit. Wage and salary increases have been minimized and all travel and meeting costs have been reduced by 10 per cent. Some programs have been curtailed and some deferred. Departmental budgets are subject to periodic review in a continuing effort to reduce expenditures.

Although the AMA has progressively increased revenues from sources other than dues, the Board of Trustees believes that to rest on a sound financial foundation, a larger proportion of financial support should come from the membership.

Meetings

June

9-11 Florida Academy of General Practice 17th Annual Scientific Assembly, Robert Meyer Motor Hotel, Orlando.

August

1- 4 Fifth Inter-American Conference on Toxicology and Occupational Medicine, University of Miami, Miami.

12-13 AMA National Conference on Infant Mortality, Fairmont Hotel, San Francisco, California.

September

16-17 Otolaryngology Seminar, University of Florida, Gainesville.

22-24 Cardiovascular Seminar, University of Florida, Gainesville.

October

20-22 "Industrial Medicine, The Doctors Role in Occupational Health," Mound Park Hospital Auditorium, St. Petersburg.

27-29 Neurology-Neurosurgery Seminar, University of Florida, Gainesville.

November

10-12 Pediatric Seminar, University of Florida, Gainesville.

17-18 Obstetrics and Gynecology Seminar, University of Florida, Gainesville.

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Council on Specialty Medicine

Editor's note: The Council on Specialty Medicine requested that each specialty present for publication a short discussion of the reasons for its recognition as a specialty group and the functions of its members. The following articles appear in this series.

T.M.

Physical Medicine and Rehabilitation

Physical Medicine and Rehabilitation is a broad specialty which developed in response to special human needs. Just as convalescent soldiers were returned to duty earlier in World War II, so are civilians today being returned to useful, gainful lives in society as a result of proper specialized supervision. The joint designation "Physical Medicine and Rehabilitation" includes the diagnosis, management and treatment of disease, defect or injury by the use of physical means and the restoration of the patient to the fullest possible physical, mental, social and economic usefulness. The specialty properly integrated with all available medical and other professional services can reduce to a minimum the handicaps associated with disability. To this specialty group must be assigned the responsibilities for the management of the difficult cases, for the organization of special rehabilitation services and for providing consultation to other physicians as necessary.

Physiatrists, as the specialists in Physical Medicine and Rehabilitation are called, are specially trained to direct the rehabilitation programs of patients requiring the combined use of the specialized disciplines, techniques and facilities that provide for the physical restoration, psychological adjustment and personal and vocational counseling, so as to foster the return to self care, self sufficiency, or productive employment. These patients are usually suffering from the effects of chronic disorders of the neuromuscular and musculoskeletal systems, conditions such as cerebrovascular accidents, the arthritides, multiple sclerosis, cerebral palsy, paraplegia and quadriplegia, chronic back pain syndrome, Parkinson's disease, amputations and others. Because of their complex nature, these conditions require the team approach by the physician, the medicosocial worker, the physical therapist, the occupational therapist, the speech therapist, the psychologist and the vocational counselor.

In this era of discovery and continued exploitation of scientific facts in medicine, the physician-scholar and medical educator alike have tended to lose sight of the patient as an individual in his environment. With this tendency to think of patients as cases, the physician-patient relationships have become attenuated. Among those physicians who shared in the redevelopment of the concept of care for the individual as a whole, the specialists in physical medicine and rehabilitation have a leading part.

Evaluative methods such as muscle testing, work load studies, electrodiagnosis and electromyography have added considerable weight to the opinions of the specialist in physical medicine and rehabilitation. He has become a source of dependable knowledge to his confreres as to how extensive a patient's involvement may be, the prognosis and how much function might remain.

The physiatrist has done much to focus attention on the values of mobilization and exercise as both preventive and curative measures. Today, this specialist is the chief exponent of the balanced prescription for physical aspects of treatment, for the balanced prescription is based on a truly searching study of the patient as a person. This is an art which takes into account medical, emotional, social and vocational factors extended through a continuum with provisions for changes as they become necessary. The specialist in physical medicine and rehabilitation is a thoroughgoing clinician specially schooled in physics, physiology and anatomy. He has extensive knowledge of neurology, rheumatology and diseases of muscles and connective tissues. He is required to know pain phenomena thoroughly and be possessed of superior social consciousness so as to further the purpose of all medicine in helping people toward a goal of medicosocial homeostasis.

The physical methods of diagnostic evaluation and treatment as used by the specialist in physical medicine and rehabilitation are often the most objective methods available and more specific than any other method in many clinical conditions. The thought that physical medicine is ancillary, adjunctive, or dispensable must be replaced by the conviction that physical procedures such as therapeutic exercise, thermotherapy, hydrotherapy, electrotherapy and electrodiagnosis are essential elements in any plan for treatment of a patient, omission of which may amount to neglect.

Pedro Arroyo Jr., M.D.
Miami

Plastic Surgery

Plastic surgery is that specialty of surgery which concerns itself principally with the improvement in appearance or function of external tissues of the body. Early in its development, plastic surgery was limited to correction of facial deformities, but its scope has been extended to include correction of defects of all external parts and, in a more limited fashion, restoration of function, as of the hands, not necessarily associated with abnormal appearance. The deficiencies which plastic surgeons are called upon to correct may be the result of congenital abnormalities, the ravages of malignant or benign tumors, the surgical removal of tissue for the eradication of tumors or the disfigurement secondary to burns or other injury.

A subdivision of plastic surgery is cosmetic surgery, which is concerned with the improvement in appearance of certain parts of the body, such as the face, ears, nose or breasts, which are unaffected by disease or injury, but are not considered aesthetically attractive.

The term plastic surgery suggests the technique of molding or arrangement of tissue already present; however, the specialty frequently makes use of two other techniques, namely, the removal of excessive issues and the addition of new tissue. The latter is accomplished either by free grafts or pedicled tissue. The most commonly grafted tissues are skin, cartilage, bone, fascia, tendon, fat and nerves. The techniques of skin grafting play such an important role in major burns that plastic surgeons are frequently called upon to care for patients following destruction of extensive areas of skin. After the healing of burns the plastic surgeon is frequently called upon to correct ulcerated, unstable, or contracted burn scars, particularly where joint motion is limited by the scars. Other scars such as disfiguring scars of the face or keloids may be improved by the plastic surgeon.

Plastic surgeons have often used homografts of skin, cartilage, and bone in various reconstructive procedures, and occasionally foreign bodies such as stainless steel, Vitallium, or various plastics such as polyethylene or silicone rubber may be employed, both as implants and as external prostheses.

Although some of the techniques of plastic surgery are used by many different types of surgeons, those who devote all of their time to this type of surgery usually take the examinations of the American Board of Plastic Surgery after a minimum of six years hospital training in general and plastic surgery. In this way assurance is given that the surgeon who has been certified by the board as a specialist is both capable and reputable.

John M. Hamilton, M.D.
St. Petersburg

Obstetrics and Gynecology

Obstetrics and Gynecology is a special branch of medicine that deals with the diseases peculiar to women and with the problems of pregnancy and parturition. Its formal conception began on Sept. 12, 1930, when the American Board of Obstetrics and Gynecology was incorporated. The original membership was composed of 200 men selected from the American Gynecological Society and the American Association of Obstetricians, Gynecologists and Abdominal Surgeons who were invited to apply for certification without examination. This list was supplemented with additional names of men who held professional titles in the medical schools until December 1931; since that time all applicants have been subjected to examination regardless of their professional position.

Pressure has been brought on the American Board to accept as candidates a small number of skillful pelvic surgeons who were concentrating on the super-radical treatment of pelvic malignant disease but who were ineligible because they lacked obstetrical training. It seems questionable that a pelvic surgeon, no matter how skillful, who has had no obstetrical training can have the proper perspective when operating on women in the childbearing period. The members of the Board have unanimously believed that the intelligent practice of gynecology, which is 80% nonoperative, depends in a large part upon a thorough knowledge of obstetrics and vice versa.

In many overlapping conditions management is shared by the urologist, radiologist, surgeon or gynecologist. In general this cooperation leads to improvement in patient care provided each specialty realizes its own limitations.

Obstetrics today is no longer a facile art to be exercised without risks by some old woman who has learned by experience. It has become an exact and difficult science, requiring from those who practice it the intelligence of the physician and the dexterity of the surgeon. No other medical discipline has more quickly applied the discoveries of recent years and none has seen the rate of morbidity and mortality shrink more rapidly. The obstetrician must be neither a useless spectator nor an injurious actor in the drama of birth.

It is truly possible to find in the art of obstetrics great happiness. Indeed, in the life of the doctor, no moment is more agreeable than that in which he realizes that through his acts a new member has been given to the family and to society. Pain and anguish give place to rest and quiet and happiness, and he takes leave of a smiling and happy couple.

This experience is certainly more pleasant than visits to the sick, where it always takes longer to bring back a smile.

Obstetrics is shared with the general practitioner and it is the opinion of most obstetricians that this happy relationship should be maintained.

Arthur J. Wallace Jr., M.D.
Tampa

Orthopaedic Surgery

Orthopaedic surgery, according to the definition adopted by the American Academy of Orthopaedic Surgeons in January 1960, is "the medical specialty that includes the investigation, preservation, restoration and development of the form and function of the extremities, spine and associated structures by medical, surgical and physical methods."

This carefully worded definition is relatively complete and implies a great deal more than is noticed at first glance. It implies the ability to pursue a logical diagnostic work-up to differentiate multiple congenital and metabolic diseases which confront the orthopaedist. It implies the application of preventive medicine in the preservation of form and function in situations where one must be able to anticipate deformity. It further describes the treatment of bones, joints, ligaments, muscle, tendon, nerve, blood vessel and integument by medicinal means, surgical procedures and casting, bracing, and appropriate exercises.

In a way, the orthopaedist is the carpenter of medicine who must, when it is indicated, as accurately as possible mend those parts bent or broken from disease or trauma insofar as is practicable. The orthopaedist is a physician and, as such, must be sufficiently aware to recognize the folly of surgical intervention where other vital systems might be compromised; but he is also a specialist in the diagnosis and treatment of maladies of the locomotor system of the human body, which excludes only the head, face and viscera. It is expected, therefore, that he use logical judgment and excellent technique in performing the mechanics as a surgeon.

Two facets of the practice of orthopaedic surgery, not implied in this definition, are the often prolonged rehabilitation required in orthopaedic patients, and the frequent occurrence of litigation and compensation in the orthopaedic practice. In the first instance, the orthopaedist must be patient and realize he may not appreciate the fruit of his labor for many months, and he must convey this sense of patience to the depressed and impatient person who has to accept bed rest or even hospital care for many weeks or months. In the second instance, he must be able to evaluate the motivations of the patient and differentiate the real from the fictitious complaint; and he must properly prepare and educate himself for participation in court room proceedings.

The orthopaedic surgeon, then, is that physician who, while trying to remain aware of those basic facts taught at medical school which pertain to all specialties, must give special attention to the form and function of the extremities and spine, considering all the facets of the individual patient's motivation, personality, physical limitation in the part treated and in other parts, to encourage the maximum rehabilitation of the whole patient.

James F. Richards Jr., M.D.
Orlando

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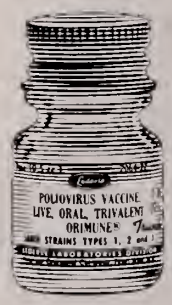
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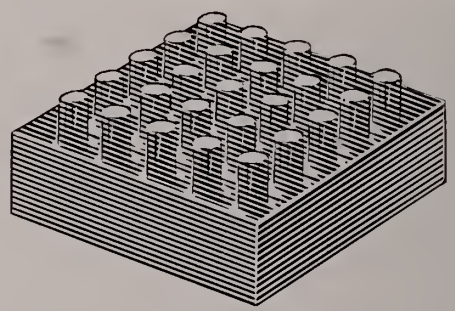


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Effectiveness—may be expected to confer active immunity against all three types of poliovirus infection in at least ninety percent of susceptibles only if given at full dosage, as directed. No characteristic side effects have been reported. There are, however, certain contraindications. These are, broadly: acute illness, conditions which may adversely affect immune response, and advanced debilitated states. In these, vaccination should be postponed until after recovery.
In infants vaccination should not be commenced before the sixth week of life. Do not give to patients with viral disease, or if there is persistent diarrhea or vomiting. ORIMUNE and live virus measles vaccine should be given separately.
Dosage—initial immunization: two doses each given orally at least 8 weeks apart. (Give a third dose to infants at 10-12 months). Booster immunization: one dose, given orally. See package literature for full directions.



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TUBERCULIN, TINE TEST
(Rosenthal) Lederle

Swab • Uncap • Press • Discard

Comparable in accuracy and reliability to older standard intradermal tests*, but faster and easier to use. Since TINE TEST is relatively painless it should receive greater patient acceptance. Results are read at 48-72 hours. The self-contained, completely disposable unit requires no refrigeration and is stable for two years.
Side effects are possible but rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. Available in boxes of 5 (new individually-capped unit); cartons of 25.

*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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Lederle

Doctor,

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mood elevation

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DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.



controlled release

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

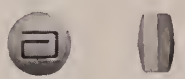
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lethamphetamine Hydro-
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5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



Front Side

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium

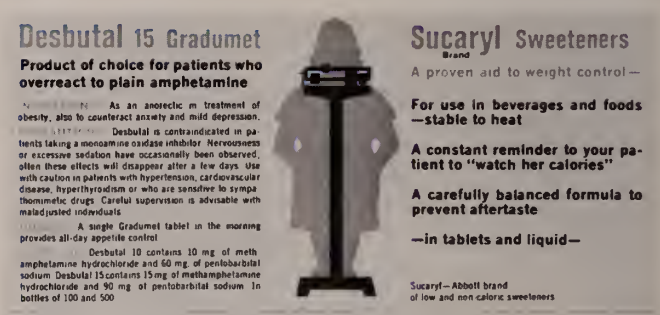


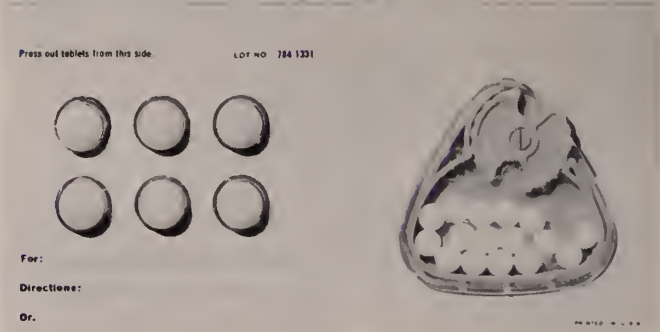
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ach sample contains 6 tablets and a filled
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economy

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CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

ABBOTT

Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
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An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

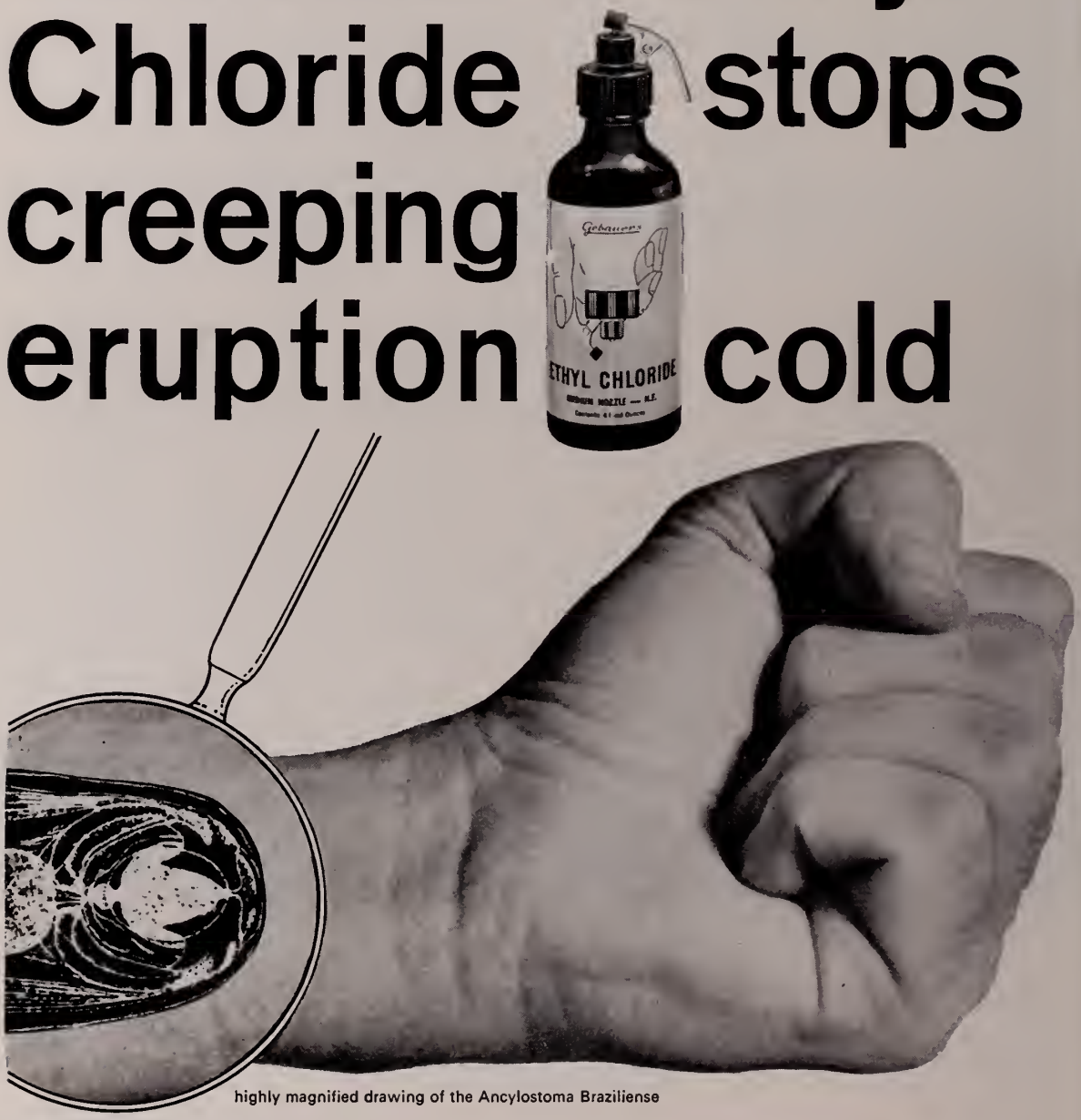
Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

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Gebauer's Ethyl Chloride stops creeping eruption cold



highly magnified drawing of the Ancylostoma Braziliense

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DORSEY Season

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Duodenal mucosa with ulcer crater—
Approx. 80× Magnification.

Loosening epithelial cells of nasal mucosa during early stage of cold—Approx. 1800× Magnification.

this issue: partners in misery

Partners in misery: common cold and duodenal ulcer*



A century or two ago our forefathers believed that the common cold was caused by an excess of evil humors. Today we regard these baleful humors as a result of the cold rather than its cause. Only in the last ten years have some of the offending viruses been cultivated, and we now know many others can be transmitted to human volunteers although they cannot yet be grown in the laboratory. Various body defenses react to infection by a virus, and in the respiratory tract the lung is protected by the phagocytic properties of the pulmonary alveolar macrophage.[1]

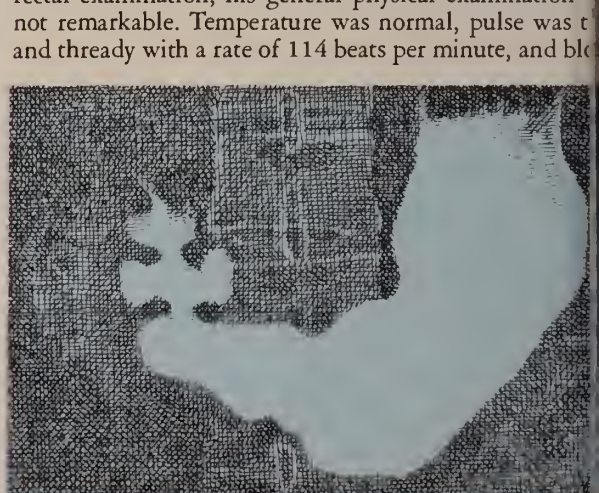
Because of the brief history and large proportion of unidentified viruses, effective prophylactic vaccines have not yet appeared. A universal antiviral agent seems even more remote. Meanwhile, these viruses continue to produce epidemics of upper respiratory infection at seasonal intervals, particularly in spring, fall and winter, during which they propagate and distribute progeny indiscriminately. As a result, they are responsible for significant work loss. Since the immunity afforded is temporary, recurrent infections are common.

This recurrent morbidity in spring and fall is shared by duodenal ulcer, itself a cause of significant loss in wages and medical expense. Thirty years ago Emery and Monroe reported 1,279 recurrences of peptic ulcer of which 13 per cent could be attributed to upper respiratory infection, thus confirmin long-held clinical impression.[2] While the infl mation, congestion and secretion of the mucos the nasopharynx in the common cold, and the hy emia and hypersecretion of the gastric mucosa ing acute exacerbation of a duodenal ulcer may be directly linked, it is probable that the miserie the infection are reflected in the pain of the ul The following case history illustrates this point.

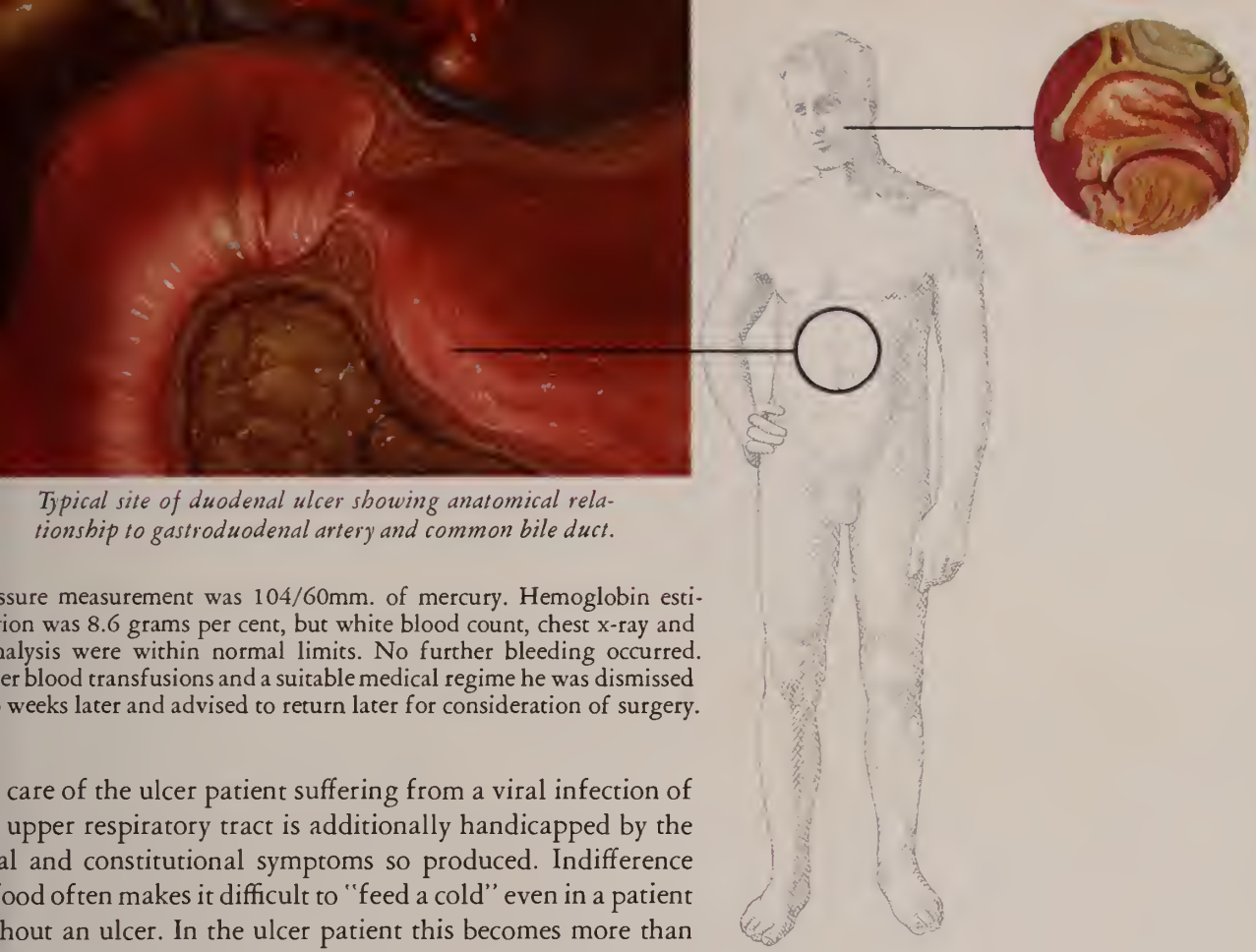
Case report A 48 year old white male executive, su ing from hematemesis and melena for 12 hours was ad ted to hospital on April 8, 1965. He gave a history of denal ulcer proved by x-ray studies 23 years previously the intervening years he suffered from typical epigas pain occurring two hours postprandially, usually for or three weeks each spring and fall. A hospital admiss two years earlier had followed hematemesis of mode amount.

The present admission was preceded by a recurrence pain during a period of unusual business pressure. In a tion he caught a cold one week before his entry to hosp and his already irregular eating habits were made mor by loss of taste and appetite, blocked nose and gen malaise. During the final 36 hours he used aspirin to lieve his cold, taking 2 or 3 tablets with a glass of water 6 or 7 occasions. Before retiring he drank a glass of toddy.

He awakened about 1 a.m. and vomited dark red bl and recently ingested food mixed with whisky. Mel followed and he was transferred to hospital. On admiss he was pale, cold and sweating. Apart from epigas tenderness and black stool on the examining finger a rectal examination, his general physical examination not remarkable. Temperature was normal, pulse was t and thready with a rate of 114 beats per minute, and bl



The commonly found "clover-leaf" roentgenographic normality of chronic duodenal ulcer due to spastic cont tions and scarring.



Typical site of duodenal ulcer showing anatomical relationship to gastroduodenal artery and common bile duct.

ssure measurement was 104/60mm. of mercury. Hemoglobin esti-ion was 8.6 grams per cent, but white blood count, chest x-ray and alysis were within normal limits. No further bleeding occurred. er blood transfusions and a suitable medical regime he was dismissed weeks later and advised to return later for consideration of surgery.

care of the ulcer patient suffering from a viral infection of upper respiratory tract is additionally handicapped by the al and constitutional symptoms so produced. Indifference ood often makes it difficult to "feed a cold" even in a patient hout an ulcer. In the ulcer patient this becomes more than omily, for malaise and apathy towards irksome routine duce a lack of interest in adhering to an ulcer program and ult in its eventual failure if these symptoms are not relieved. e absence of curative treatment for these viral infections has wned many a strange therapeutic offspring and some of the re generally accepted remedies contain a special risk for the er patient.

the gastric physiologist, the shot heard around the world s not fired at Concord but was discharged through the stom- of Alexis St. Martin. The worthy voyageur had a more n modest thirst and on several occasions William Beaumont served through the resulting fistula the changes of gastritis ich followed an immoderate ingestion of alcohol.[3] It is now ll known that alcohol stimulates the production of gastric ce and the patient with an ulcer, even in remission, should drink alcohol without first taking food, milk or antacid. e use of various alcoholic remedies for the common cold is be strongly discouraged in this type of patient. Factors al-dy present can produce an acute exacerbation of ulcer symp-ns without the added stimulus of alcohol.

adache and facial pain, sore throat and generalized aching subjective discomforts of viral infections of the upper res-atory tract or their complications. Relief from them is ually sought in the family medicine cabinet, and of all the dications habitually stored there, salicylates are the most quently used. Oral ingestion of salicylates has produced



I can taste, Doctor!

On Sippy diet or unrestricted regimen, food tastes better to the patient with a cold when you prescribe the oral decongestant

Triaminic® *tablets*

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
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One tablet on arising, in midafternoon and at bedtime assures round-the-clock relief. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

(Advertisement)



substernal pyrosis and sometimes epigastric pain in susceptible individuals. Bleeding from erosions of the gastric mucosa has followed their use and has been severe enough in some instances to cause hematemesis and melena.[4] It has been suggested that interference with the protective mucous layer of the stomach allows this to happen. There is no evidence that hypersecretion occurs, but the taking of aspirin has been followed by exacerbation of ulcer symptoms and occasionally by gastrointestinal bleeding.[5] The ulcer patient with a cold should take salicylates with an antacid, or preferably other means of symptomatic relief should be found.

Caffeine has two actions on gastric secretion. One directly stimulates production of acid and the other potentiates the out-pouring of gastric juice as a response to other stimuli.[6] In high doses to animals, it has produced erosive gastritis and peptic ulceration. Caffeine-containing beverages are discouraged for the ulcer subject and forbidden during an acute exacerbation.[7] Many cold remedies contain caffeine.

To sufferers from allergic rhinitis springtime brings symptoms of nasal obstruction, loss of taste and smell and malaise similar to those caused by viral infection but due instead to allergens which at that time of year are principally tree pollens. Relief from these symptoms can be obtained, though not wisely, by the use of steroid medication. Unfortunately, chronic sufferers from these allergies have used this approach with varying degrees of success. Steroid hormones increase gastric secretion and delay the healing of experimental ulcers.[8,9] Clinically their administration has been associated with reactivation of healed duodenal ulcers, and with bleeding and perforation which were not always preceded by typical ulcer distress. Because of these harmful effects, their use in the ulcer patient is best avoided for other than serious medical problems and then only with adequate antacid coverage.

Summing up It is immaterial by which pathways the malaise and lassitude, depression and irritability activate an ulcer, but it is the physician's responsibility to ensure that the medications he selects to relieve the symptoms of a cold do not further aggravate the ulcer.

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Each teaspoonful (5 ml.) contains:

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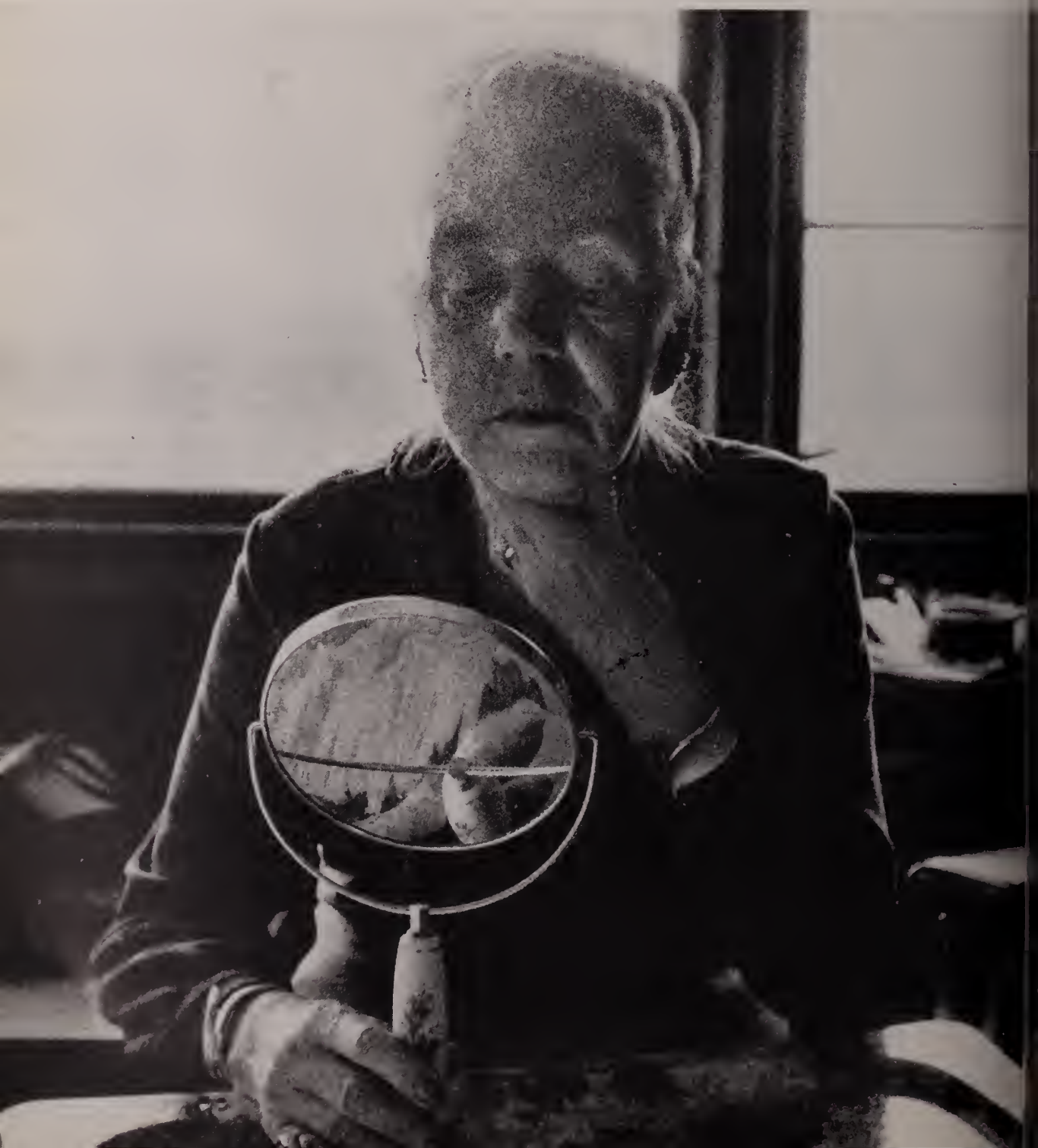
Over 185 million doses prescribed

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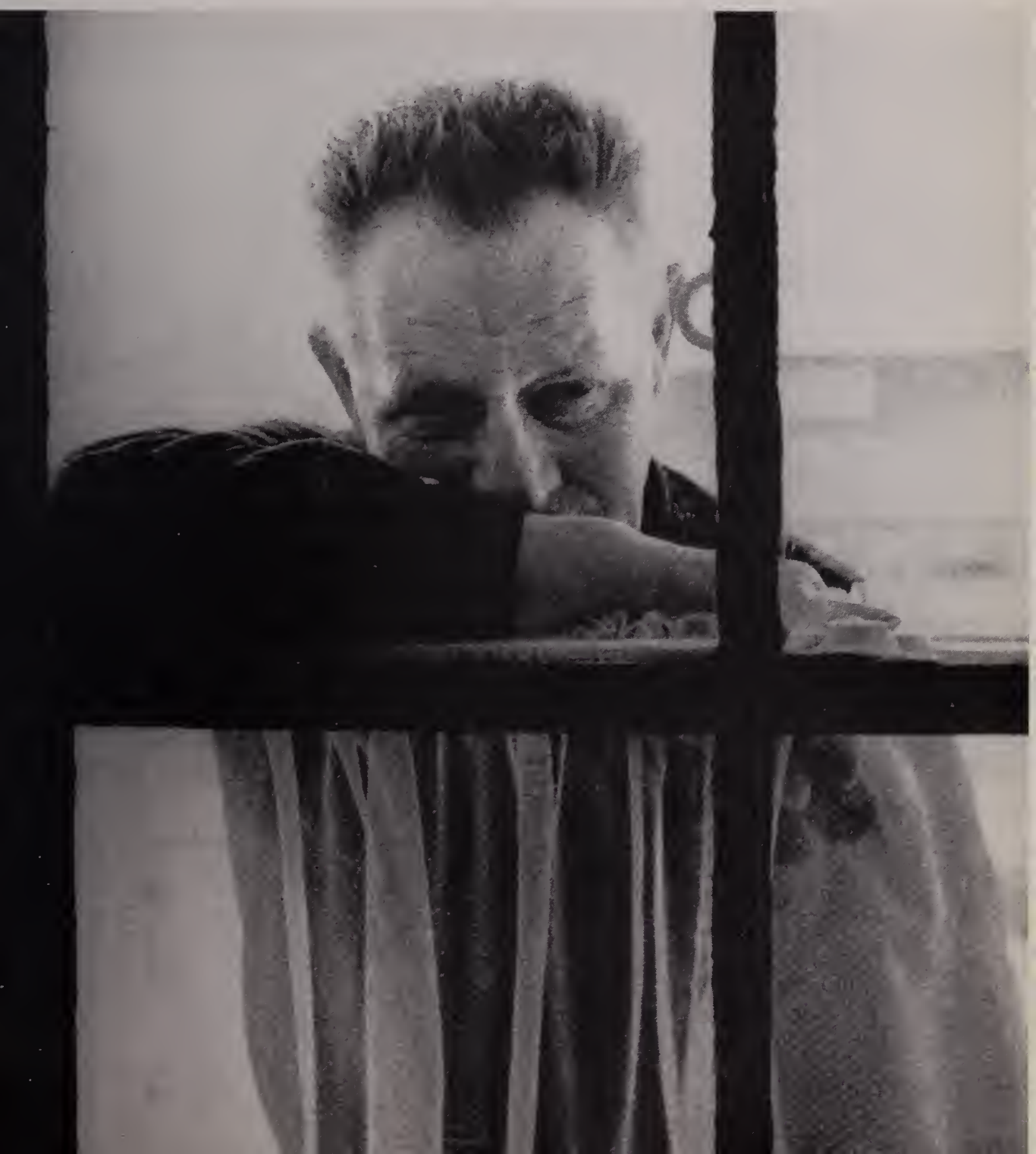
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There is a growing senescent body of people who —either from lack of motivation, or as a result of surgery, trauma, or extended illness—are on their way to malignant inactivity...



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Some may be not quite sick, nor yet quite well. They may complain of too easy fatigue, of vague aches and pains.
Many need your assurance that they are not as old as they feel...

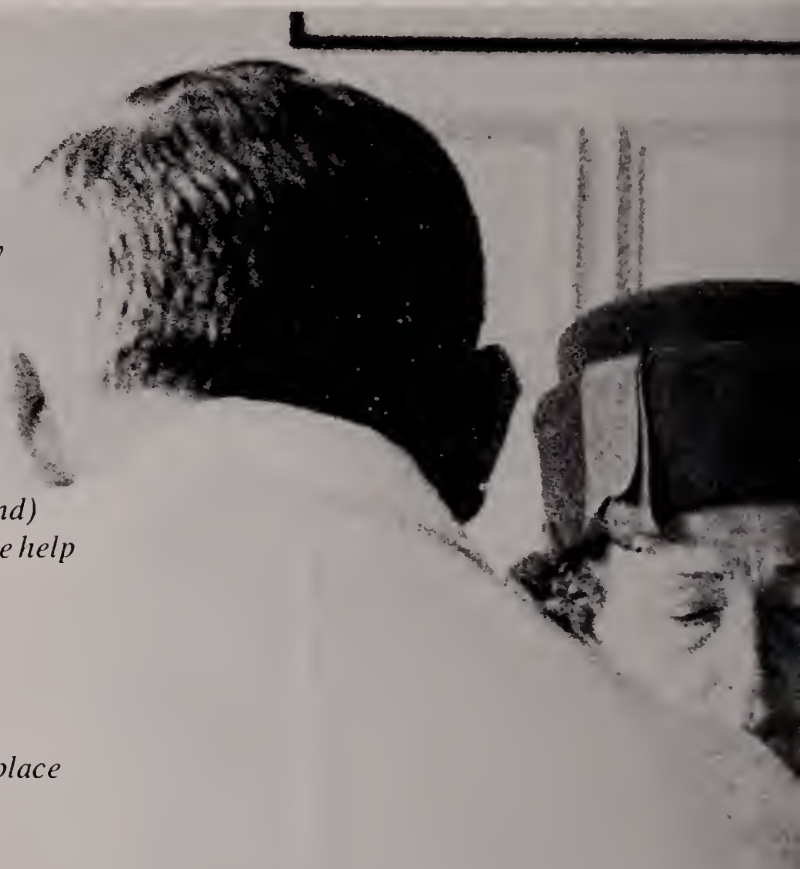


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Frequently, they become "the waste-aways."
They have simply lost interest in
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often through the feeling
that they are no longer needed.



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McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

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Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

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Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

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Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

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Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.

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Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
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steroid-nutritional compound

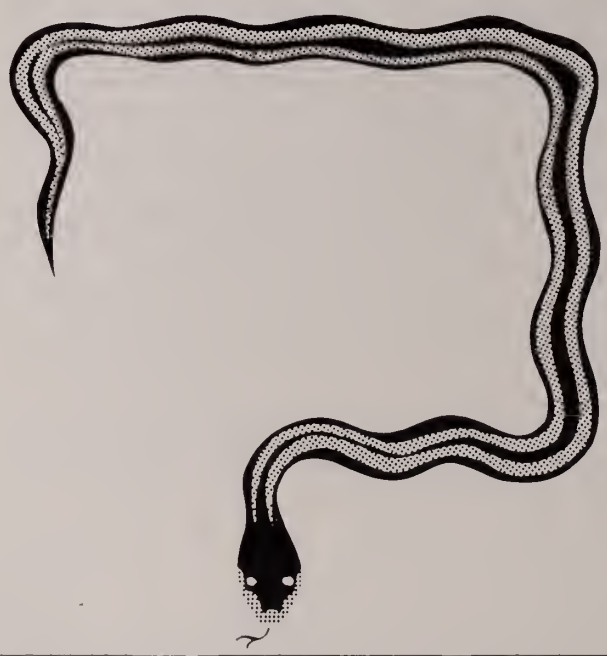
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helps restore normal motility and tone

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide) —25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL —containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established.
**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

Side Effects and Contraindications: Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.



GERILID™

Each chewable tablet contains:
nicotinic acid (niacin) 75 mg. and
aminoacetic acid (glycine) 750 mg.

Administration and Dosage: One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

Supplied: Packages of 50 chewable tablets.

Also available in liquid form as Geriliquid®, in bottles of 8 and 16 ounces.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

Obstetrical or post—surgical patients requiring a dependable increase in hemoglobin will receive as much iron (250 mg. in a 5 cc. ampul) as in one pint of blood. Imferon (iron dextran injection) is less expensive and it avoids the well-recognized hazards of whole blood transfusion. When patients cannot—or cannot be relied upon to—take oral iron, Imferon (iron dextran injection) will rapidly supply needed iron for reserve stores.



IMFERON®
(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a *source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

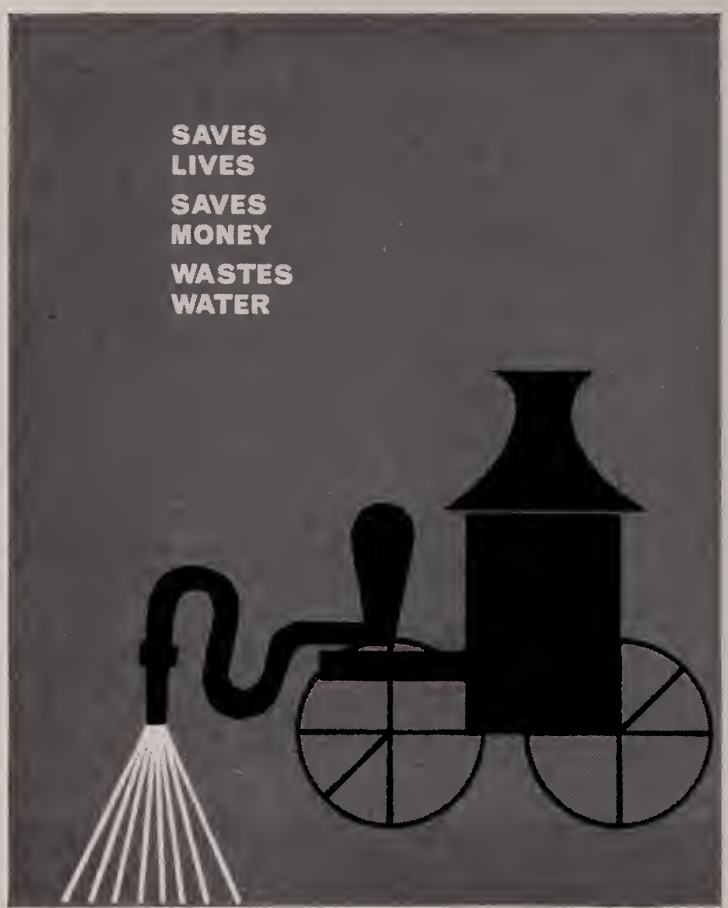
CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE
PRODUCTS
FOR PATIENTS
YOU SEE
EVERY DAY

METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides.* Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day.*



METAHYDRIN®

(trichlormethiazide)

oral diuretic

Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY



Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.

METATENSIN®

Each scored tablet contains:
METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY



NORPRAMIN®

(desipramine hydrochloride)

non-sedating · rapid-acting
ANTIDEPRESSANT

overcomes guilt, lifts depression, restores confidence

Feelings of guilt, worthlessness, emptiness and loss frequently characterize depression. Such feelings, along with insomnia, physical complaints, sadness, apprehension, and other symptoms of depression rapidly respond to Norpramin (desipramine hydrochloride). Improvement often begins in 2-5 days, sometimes in less. A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Side effects, usually mild may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

In colicky infants Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying and improves feeding patterns. It permits sleep and rest for patient and family. The less than hypnotic amount of phenobarbital in the recommended dose affords a mild, calming action and enhances the antispasmodic action of Piptal (pipenzolate bromide). The latter drug, as reported in the medical literature, has a favorable ratio of effectiveness to side-effects which is unusual in anticholinergics and thus is particularly appropriate to pediatric use.



PEDIATRIC PIPTAL® WITH PHENOBARBITAL

each cc. contains 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol.

Pleasant-tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be given by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. It is contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

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Whitney
Darrow



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When you're called upon to provide quick relief for the sinusitis patient, Novahistine Singlet will usually do the job.

A single tablet provides prompt analgesic effect for relief of sinusitis pain. Then Novahistine Singlet also attacks the underlying cause of the headache—helping to open blocked respiratory passages and restore normal sinus drainage. The continuous decongestant effect produced by one Novahistine Singlet every 8 hours helps reduce the chance of acute sinusitis progressing to chronic stages.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that Novahistine may occasionally cause drowsiness. Each tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

NOVAHISTINE®
SINGLET™

For relief of sinusitis pain and congestion.

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

Thanks to Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

'Dexamyl' does more than most anorectics. Because it curbs appetite *and* lifts mood, 'Dexamyl' can encourage the discouraged dieter to stay on her diet.

The mood lift with 'Dexamyl' can make the difference between the success or failure of her diet plan.

Formulas: Each 'Dexamyl' Spansule® Capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

Before prescribing, see SK&F product Prescribing Information.

she can say "No thank you" to the crêpes suzette.

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FOR A CLEAN START IN VAGINITIS THERAPY

superior cleansing action ■ STOMASEPTINE is "a highly effective mucolytic cleansing agent"[1] that removes debris and flushes out secretions more thoroughly than acid douches.[1] Alkaline STOMASEPTINE "dissolves and removes leukorrheal secretions"[1]—whereas acid douches tend to "coagulate or set the vaginal contents."[2] Low surface tension and release of nascent oxygen contribute to deep penetration and cleansing of rugae.

enhances specific therapy ■ Thorough cleansing of the vaginal vault with STOMASEPTINE enhances the effectiveness of specific vaginitis therapy, ensures maximum contact of topical medication with mucosa.

excellent patient acceptance ■ Anti-pruritic and soothing, pleasantly scented—patients feel "fresh and clean."

1. Weese, H.: Personal Communication, Sept. 25, 1964. 2. Glynn, R.: Obst. & Gynec. 20:369, 1962.

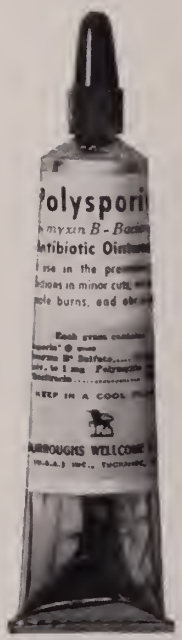
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6 oz. and 15 oz. jars; cartons of 12 10-gm. packets

Literature and professional supply on request.

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DOUCHE POWDER

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in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Contraindication:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: In ½ oz. and 1 oz. tubes
Complete literature available on request from Professional Services Dept. PML.

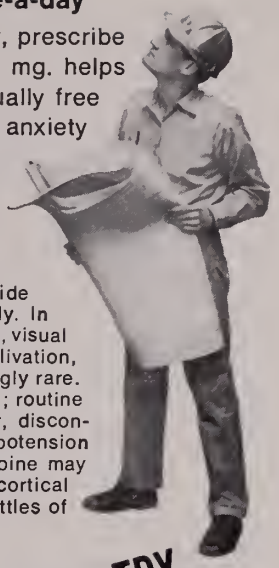
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TRADE MARK®

Blueprint for dealing with tension due to stress — Prolixin — once-a-day

For the patient who must be on the job mentally as well as physically, prescribe Prolixin. The prolonged tranquilizing action of as little as one or two mg. helps him cope with tension all day long. Markedly low in toxicity and virtually free from usual sedative effects, Prolixin is effective in controlling both anxiety associated with somatic disorders and anxiety due to environmental or emotional stress. Patient acceptance is good — because Prolixin is low in cost, low in dosage and low in sedative activity. Prescribe Prolixin.



Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

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THE SQUIBB TRANQUILIZER

SQUIBB FLUPHENAZINE HYDROCHLORIDE

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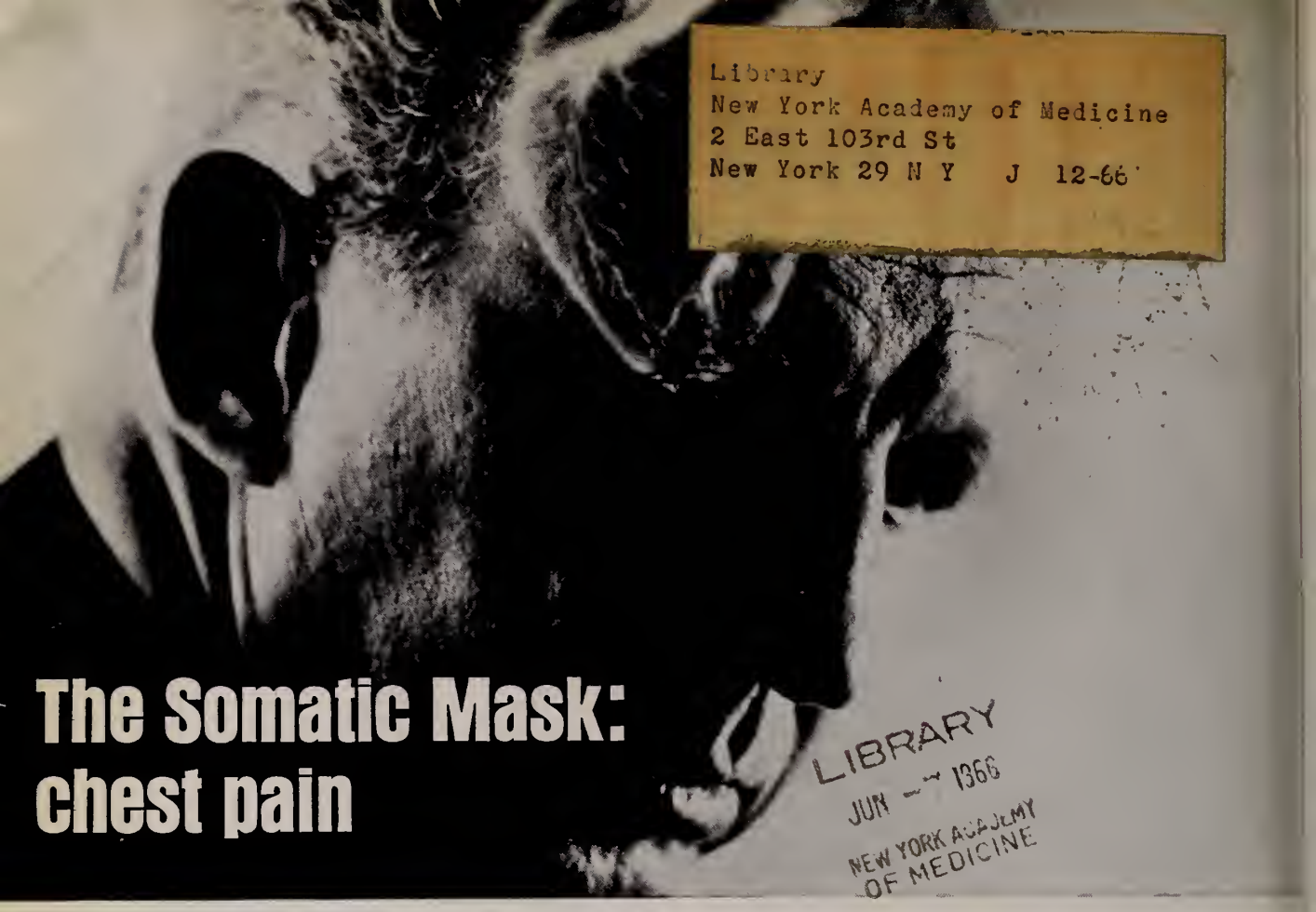
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The Somatic Mask: chest pain

heart disease or psychic tension?

"Heart symptoms"—chest pain, tachycardia, arrhythmia—invariably alarm and preoccupy the patient, though they may be completely without organic basis. Such symptoms often are somatic masks of psychic tension, arising from constant encounters with stressful situations.

When the problem is diagnosed as emotionally produced, consider Valium (diazepam) as adjunctive therapy. Valium (diazepam) acts rapidly to calm the patient, to reduce his psychic tension and relieve associated cardiovascular complaints.

Neurotic fatigue—the chronic tiredness resulting from emotional strain which so often accompanies psychogenic "heart" symptoms—also can be controlled by this highly useful agent. Valium (diazepam) often achieves results where other psychotherapeutic agents have failed.

Valium (diazepam) is generally well tolerated, and usually does not impair mental acuity or ability to function. If side effects such as ataxia and drowsiness occur, they usually disappear with dosage adjustment.

In prescribing: Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hrs, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Supplied: Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 for convenience and economy in prescribing.

Valium®(diazepam)

2-mg, 5-mg, 10-mg tablets

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